

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05211  
Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 year, 21 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 1 year, 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 4430 Falls Terrace, S. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

PATRICIA E. BAILEY

## 3. (b) Social Security Number

235-34-4262

4. Sex..... Female  
5. Color or race..... Negro  
6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... May 28, 1924  
6. (c) If alive, give age..... years

8. AGE: Years..... 23 Months..... 11 Days..... 8 If less than one day..... hrs. .... min.

9. Birthplace..... Buchanan, West Virginia  
(Town, county, and state)

10. Usual occupation..... Waitress

11. Industry or business.....

12. Name..... Mathew Bailey

13. Birthplace..... Western, West Virginia

14. Maiden name..... Hazel Munford

15. Birthplace..... Buchanan, West Virginia

16. Informant..... Deceased

Address.....

17. Removal..... Date thereof..... May 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... to Washington D.C.

18. Funeral director..... MALVAN + SCHOY FNC.

Address..... 424 - R ST. N.W.

19. May 6, 1948 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 6<sup>th</sup> 1948 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14<sup>th</sup> 1947 to May 6<sup>th</sup> 1948 and that I last saw her alive on May 6<sup>th</sup> 1948.

Immediate cause of death..... Pulmonary Tuberculosis. DURATION 1 yr 3 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

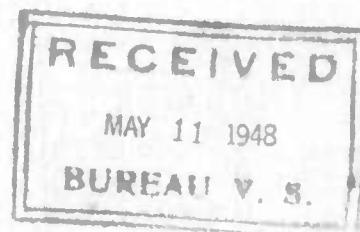
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finucane M.D.

Address..... Glenn Dale Md Date signed..... 5/6/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Cheverly  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 hours  
 Hospital, institution, or street address where death occurred:  
Prince George's General Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Washington D. C.  
 City or town Washington D. C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 611 7th Street S. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Wilbert Thomas Bailey

## 3.(b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced separated  
 6.(b) Name of husband or wife Emma J. Bailey  
 6.(c) If alive, give age 43 years  
 7. Birth date of deceased (mo., day, yr.) June 6, 1899  
 8. AGE: Years 48 Months Days If less than one day  
 hrs. min.

9. Birthplace Virginia  
 (Town, county, and state)  
Carpenter  
 10. Usual occupation  
 11. Industry or business

FATHER 12. Name James S. Bailey  
 13. Birthplace Virginia  
 MOTHER 14. Maiden name Neda Compton  
 15. Birthplace Virginia

16. Informant Mrs. Emma J. Bailey  
 Address 612 7th st S W Washington D. C.

17. Burial Date thereof May 24 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Elkwood Cemetery  
 Location Culpepper Rd, Va.

18. Funeral director W.W. O. Harris  
 Address 577-11 St. E. Wash. D.C.

19. 5/22 19 48 Amanda Coroney  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1948 at 2:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 to 19  
 and that I last saw h. alive on 19

Immediate cause of death  
Non-anteropneal and  
shock  
 Due to fracture of pelvis, laceration  
fractured femoral femoral  
artery  
 DURATION

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of 5-21-48  
 Where did injury occur? not known (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) not known (City or town) (County) (State)

Means of injury fell from roof Injured at work? yes  
Deputy Medical Examiner

23. SIGNATURE James P. [illegible] M.D. or other  
 Address Reston Va Date signed 5-21-48

RECEIVED

MAY 25 1948

BUREAU V. S.



Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 116 JUN 15 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George  
City or town Princetown Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 hrs. 47 minutes  
Hospital, institution, or street address where death occurred:  
Island Memorial Hospital  
How long in hospital or institution? 14 hrs. 47 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Seat Pleasant - Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6615 Central Ave -  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

James Franklin Ball  
4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 6, 1895

8. AGE: Years 62 Months 8 Days 27 If less than one day  
hrs. min.

9. Birthplace Washington D.C.  
(Town, county, and state)

10. Usual occupation Retired Railroad Man

11. Industry or business Washington Terminal Co -

12. Name Henry S. Ball

13. Birthplace Washington D.C.

14. Maiden name Mary Beulah Foreman Ball

15. Birthplace Virginia

16. Informant Fred H. Ball

Address 111 D. St. South East Wash. D.C.

17. Bureau Date thereof 5/4/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Wash. D.C.

18. Funeral director Wm. T. Hatcher & Co

Address 577-11 St. S.E.

19. May 30, 1948 (Date rec'd by registrar) Registrar Amanda W. Foreman

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1948 at 6:27 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. years, 10. months, 19. days

and that I last saw him alive on 19. years, 10. months, 19. days

Immediate cause of death Diabetic coma

Due to Diabetes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James S. V. Foreman M. D. or other

Address Forestville Md Date signed 5-3-48

MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 5 1948

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 142

## 1. PLACE OF DEATH:

County Prince George's

City or town Capital Heights  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb 20, 1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

50

hrs.

min.

9. Birthplace

Washington DC.  
(Town, county, and state)

10. Usual occupation

Aid in

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1948

Carrie F. Campbell  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Capital Heights  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

6114-C Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Intra Cranial hemorrhage

DURATION

Due to

Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Address

M. D. or other

Date signed 5-12-48

RECEIVED

MAY 14, 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05215  
Reg. Dist. No. 243

1. PLACE OF DEATH:  
County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 yr., 3 mos., 25 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 1 yr., 3 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 835 - 18th St., N. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

MARY E. BEANE

3. (b) Social Security Number

4. Sex..... Female  
5. Color or race..... Negro  
6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... James D. Beane

7. Birth date of deceased (mo., day, yr.)..... September 27, 1911  
6. (c) If alive, give age..... 40 years

8. AGE: Years Months Days If less than one day  
36 36 7 13 hrs. min.

9. Birthplace..... Northumberland, Virginia  
(Town, county, and state)

10. Usual occupation..... Printer's Assistant

11. Industry or business.....

12. Name..... Warner Davenport

13. Birthplace..... Northumberland, Virginia

14. Maiden name..... Addie L. Haynie

15. Birthplace..... Northumberland, Virginia

16. Informant..... Deceased

Address.....

17. Removal..... Date thereof..... May 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... to Washington

18. Funeral director..... Maloney & Schrey Inc.

Address..... 424 - R St. N.W.

19. May 11, 1948 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 10th 1948 at 11:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14th 1947 to May 10th 1948 and that I last saw him alive on May 10th 1948

Immediate cause of death.....

Pulmonary Tuberculosis  
DURATION 1 yr 19 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finucane M.D.  
M. D. or other

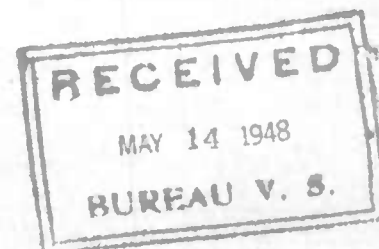
Address..... Glenn Dale, MD Date signed 5/10/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Temple Hill Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Temple Hill Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4505 - Temple Lane S. E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret J. Blyth

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife John M.

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 2 - 18978. AGE: Years 50 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Spokane Washington  
(Town, County, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "16. Informant John M. Blyth

Address

17. Cremation Date thereof May 7 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Smithland Md.18. Funeral director Arthur E. Simmons Jr.Address 2007 - Nichols Ave S.E.19. May 5 19 48 Howard P. Bease  
(Date recd. by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 19 48 at 8:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3, 19 47, to May 5, 19 48, and that I last saw him alive on May 4, 19 48Immediate cause of death Carcinoma of the ovary with metastasisDURATION  
5 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas F. Collins MD

M. D. or other

Address 322 H O P N E Date signed 5-5-48

CERTIFICATE OF DEATH

CIVIL DIVISION

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED  
MAY 8 1948  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1008

05217

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Clevery  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 daysHospital, institution, or street address where death occurred: Prince Georges Hosp. LabHow long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Halls, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war none

## 3. (a) FULL NAME

Mrs. Margaret Boice

## 3. (b) Social Security Number

## 4. Sex

Fem.

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bertram

## 7. Birth date of deceased (mo., day, yr.)

May 10, 1883

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

65

hrs.

min.

## 9. Birthplace

Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Edward S. Boice

## 13. Birthplace

Washington D.C.

## 14. Maiden name

Ann of Sophronia Dwick

## 15. Birthplace

unk.

## 16. Informant

Husband - Bertram

## Address

Halls, Md

## 17.

(Burial, cremation, or other disposal)

## Date thereof

May 10 1948  
(month) (day) (year)

## Cemetery or place of burial

West Oak Cemetery

## Location

Mitchellville, Maryland

## 18. Funeral director

## Address

300 4th St NE, Washington D.C.

## 19.

May 10 1948  
(Date recd by registrar)Carrie F. Campbell  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 May 1948 at 10:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23, 1947 to May 7, 1948and that I last saw her alive on May 7, 1948Immediate cause of death MyocardialThrombosis

## DURATION

Due to Abdominal Atherosclerosis2. Peasantry

Due to

Other conditions Thrombotic phlebitis ofLeft Femoral and Inferior Vena Cava

(Include pregnancy within months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B. Sasser

M. D.

Address Upper Marlboro, MdDate signed 7 May 48

**RECEIVED**

MAY 13 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05218

Reg. Dist. No. 243.

1. PLACE OF DEATH: Prince Georges  
County.....  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1701 15th Street, N. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

3. (a) FULL NAME Grace Bourke

3. (b) Social Security Number  
- - - -

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Separated  
6.(b) Name of husband or wife Albert Bourke  
7. Birth date of deceased (mo., day, yr.) March 29, 1904  
8. AGE: Years 44 Months 44 Days 2 It less than one day  
..... hrs. .... min.

9. Birthplace Cape Maine, New Jersey  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business - - -

12. Name Sickles Beaman  
13. Birthplace Warsaw, North Carolina  
14. Maiden name Mary Murphy  
15. Birthplace Magnolia, North Carolina

16. Informant Deceased  
Address

17. removal Date thereof May 2, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Washington  
Location D. C.

18. Funeral director W. Ernest Jarvis Co.  
Address 1432 U. St., N.W., Washington, D. C.

19. 5-2-1945 Rowland S. Philips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1948 at 11:20 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1948 to May 1 1948  
and that I last saw him alive on May 1 1948  
Immediate cause of death Pulmonary Tuberculosis  
DURATION 7 months  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.  
M. D. or other  
Address Glenn Dale, Md Date signed 5-1-48

MARCON RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131a 05219 245

## 1. PLACE OF DEATH:

County Prince Georges County

City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 1/2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ward Edward Bower

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Lillian R. Bower

## 7. Birth date of deceased (mo., day, yr.)

April 4<sup>th</sup> 1884

6. (c) If alive, give age 50 years

## 8. AGE:

Years 64

Months 1

Days 21

If less than one day

hrs. min.

## 9. Birthplace

Shell City, Missouri  
(Town, county, and state)

## 10. Usual occupation

retired

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

William Edward Bower

## 13. Birthplace

Hillsboro, Ohio

## 14. Maiden name

Abbie Goodrich

## 15. Birthplace

Columbia, Kansas

## 16. Informant

Lillian R. Bower

## Address

4102 - Roanoke St.

## 17.

Burial

Date thereof May 27 1948  
(month) (day) (year)

## Cemetery or crematory

Monett Cemetery

## Location

Monett Missouri

## 18. Funeral director

## Address

W.W. Chawkes &  
Riverdale - Ind.

## 19.

(Date rec'd by registrar)

May 26 1948

Mrs. J. A. Severe  
Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Prince Georges County

City or town

Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4102 - Roanoke St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 25<sup>th</sup>

19 48

at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14<sup>th</sup>

19 48

to May 25<sup>th</sup> 19 48

and that I last saw him alive on

May 25<sup>th</sup>

19 48

Immediate cause of death

Uremia

Due to

Cardio vascular renal  
disease

Due to

DURATION

3 months  
years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

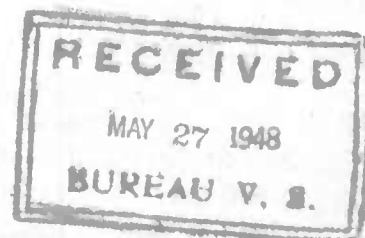
Ronald S. Flinders M.D.

M. D. or other

Address

5401 - 25<sup>th</sup> St. Hyattsville

Date signed 5-25-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Hyattsville Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 64 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Andrew Joseph Brade camp

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (c) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) Feb 5, 18828. AGE: Years 64 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Md.  
(Town, county, and state)10. Usual occupation Gardner

11. Industry or business:

12. Name John Brade camp13. Birthplace Md.14. Maiden name Annie schaeffer15. Birthplace Germany16. Informant annie J. SwingleAddress Hyattsville Md17. Burial Date thereof May 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Geo WashingtonLocation Hyattsville Md.18. Funeral director G. Gaschi sonsAddress Hyattsville Md.Date signed by registrar May 19 1948 James Leroy

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince GeorgeCity or town Hyattsville Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 13413 Hamilton st  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1948 at 6:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 3, 1948 to May 17, 1948and that I last saw him alive on May 14, 1948Immediate cause of death CardiovascularDue to Excess arterial sclerosisslight cerebral hemorrhageDue to Alcohol 1/2 ouncemisuse of aspirin

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Shirley P. R...Address Hyattsville MdDate signed May 19 1948

M. D. or other





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Chesley, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 hrs. 15 min.  
 Hospital, institution, or street address where death occurred:  
Prince George's Hospital  
 How long in hospital or institution? 4 hrs. 15 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges  
 City or town Hyattsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5414-15th Plac. E  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Baby Giel Bunnell

## 3. (b) Social Security Number

4. Sex Female 5. Color or race WW 6.(a) Single, married, widowed, or divorced In Font  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) 5-24-48  
 8. AGE: Years Months Days If less than one day  
4 hrs. 15 min.

9. Birthplace Chesley, Md  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George Bunnell  
 13. Birthplace Phoenix Arizona  
 MOTHER 14. Maiden name Gloria Butler  
 15. Birthplace Chesley, DC

16. Informant Lotter

Address

17. Cremation Date thereof 5/25/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Prince George's General Hospital  
Chesley, Md.  
 Location

18. Funeral director A. J. Bealey, Supt.Address Chesley, Md.

19. 6/3 19 48 Amanda Downey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 48 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/24 19 48 to 5/24 19 48  
 and that I last saw him alive on 5/24/48 19 48

Immediate cause of death Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas A. Christensen, M.D.

Address College Park, Md Date signed 5/25/48

RECEIVED

JUN 4 1948

BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 232

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Upper Marlboro Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:  
noneHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Upper Marlboro, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. R#1  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Richard Howard Butler

## 3. (b) Social Security Number

—

## 4. Sex

M

## 5. Color or race

Col

## 6. (a) Single, married, widowed, or divorced

married

## B. (b) Name of husband or wife

Clara Butler

## 7. Birth date of

deceased (mo., day, yr.)

Sept 24, 19038. (c) If alive, give age 1 years

## 8. AGE:

Years

Months

Days

If less than one day

4481

hrs.

min.

## 9. Birthplace

Upper Marlboro, Md.  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Farm

FATHER

## 12. Name

Arthur Butler

## 13. Birthplace

Charles Co., Md

MOTHER

## 14. Maiden name

Mary Lowery

## 15. Birthplace

Maryland

## 16. Informant

Clara Butler - WifeAddress Upper Marlboro, Md.

## 17.

BurialDate thereof May 28, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

Mt. Carmel

## Location

P. O. Box 6, Md.

## 18. Funeral director

Pittie Bros.

## Address

Upper Marlboro, Md.

## 19.

May 26, 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 48 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 19 48 to May 25 19 48and that I last saw him alive on May 24 19 48Immediate cause of death acute myocardial  
decompensation with  
pulmonary edema  
Due to cardiovascular  
renal disease

## DURATION

3 days  
unknownOther conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide natural causesWhere did injury occur? —

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE Richard H. Butler

M. D. or other

Address Washington 1900 Date signed May 25, 1948

RECEIVED

, MAY 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? hrs.

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? hours

## 3. (a) FULL NAME

Margaret Campbell

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Benjamin R. Campbell

7. Birth date of

deceased (mo., day, yr.)

July 22, 19066. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

41902648hrs.min.9. Birthplace Rockland Maine

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Willard Jackson13. Birthplace Rockland, Me.14. Maiden name Frances Robinson15. Birthplace Rockland, Me.

16. Informant

Address

17. Body Removal thereof 5/18/48  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory

Fort Lincoln Cem.

Location

Washington, Balto. Rd. & Dade Line18. Funeral director J. F. Costello

Address

1722-N. Cap. St. Wash. D.C.19. 5/18 48

(Date recd by registrar)

Amanda Doney

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Chillum  
(If outside city or town limits, write RURAL and give nearest town)Street No. Riggs Road and Eastern Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1948 19 48 at 11 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 May 1948 to 18 May 1948 and that I last saw him alive on 18 May 1948

Immediate cause of death

UREMIC TOXEMIA

DURATION

2 days +Due to CHRONIC DEGENERATIVE 10 yr + ?  
NEPHRITIS; CARDIACDue to HYPERTROPHY;  
TOXIC PNEUMONIA

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?23. SIGNATURE W. L. Emeric M. D.Address Beimyn Date signed 5-18-48

RECEIVED  
MAY 20 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1310 05224

1. PLACE OF DEATH:  
County Prince George's  
City or town Woodmore, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death 1 Year  
Hospital, institution, or other address where death occurred 20 Mitchellville, Md.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Woodmore, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Enterprise Road.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

3. (a) FULL NAME  
Sarah Virginia Carter  
Sex Female Color of race White 6.(a) Single, married, widowed, or divorced Widowed  
Name of husband or wife Staunton Carter

3. (b) Social Security Number

6. (b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) Sept. 24, 1863  
6. (c) If alive, give age years

8. AGE: Years 84 Months 7 Days 13 It less than one day 7 hrs. 15 min.

9. Birthplace Hughesville, Md.  
(Town, county, and state)

10. Usual occupation Own home

11. Industry or business Own home

12. Name Harry A. Carter

13. Birthplace Hughesville, Md.

14. Maiden name Alice Catherine

15. Birthplace Charlotte Hall, Md.

16. Informant Mrs. Raymond Walker

17. Burial Date thereof 5/11/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Field

Location Hughesville, Md.

18. Funeral director Hunt & Ryan

Address Wadsworth, Md.

19. 5/10 1948  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1948 at 7:54 A.M.  
21. CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 to May 1948  
and (a) last saw him alive on May 8, 1948

Immediate cause of death Cardiac, Renal disease  
Due to Intestinal  
reflexitis  
Due to

DURATION

1 yr  
6 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Apgar, M.D.  
M. D. or other

Date of signature Sept 19, 1948

Place of signature Rock Hill, S.C.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
MAY 12 1948  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05225  
Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 month, 4 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 1 month, 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 3407 Sherman Avenue, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

VALERIE Cobbs

### 3. (b) Social Security Number

---

4. Sex..... Female  
5. Color or race..... Negro  
6.(a) Single, married, widowed, or divorced..... Single  
6.(b) Name of husband or wife.....  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... May 22, 1919  
8. AGE: Years..... 28 Months..... 11 Days..... 14 It less than one day..... hrs. .... min.

9. Birthplace..... Red Spring, North Carolina  
(Town, county, and state)  
10. Usual occupation..... Maid  
11. Industry or business.....

12. Name..... Amos Cobbs  
13. Birthplace..... Red Spring, North Carolina  
14. Maiden name..... Estella McGoey  
15. Birthplace..... Red Spring, North Carolina

16. Informant..... Deceased  
Address.....

17. Removal..... Date thereof..... 5/7/48.  
(Burial, cremation, or removal, Which?) (month) (day) (year)

18. Funeral director..... John T. Rhines Co.  
Address..... 901 3rd St S.W. Wash. DC

19. 5/7 48. Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 6 1948, at 4:00 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948 to May 6 1948 and that I last saw her alive on May 6 1948.  
Immediate cause of death..... Pulmonary Tuberculosis  
DURATION..... 5 months  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finucane M.D.  
M. D. or other  
Address..... Glenn Dale, Md. Date signed..... 5/6/48.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 15 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Pr. George  
 City or town Ritchie Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Years 5 Months  
 Hospital, institution, or street address where death occurred:  
6363 - Dorsey Road SE  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 424 Salem Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Frank Thomas Delaney

## 3.(b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of Mary Edith Delaney wife  
 7. Birth date of deceased (mo., day, yr.) 1871  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 77 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sharpsburg Md.  
 (Town, county, and state)  
 10. Usual occupation Resturant Owner  
 11. Industry or business Own Resturant  
 12. Name Thomas Delaney  
 13. Birthplace Ireland  
 14. Maiden name Julia Eeton  
 15. Birthplace Maryland

16. Informant Mrs Mary Gladys Simmons  
 Address 6363 Dorsey Rd S.E. Wash 19 D.C.  
 17. Burial Date thereof May 21 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mountain View  
 Location Sharpsburg Md.  
 18. Funeral director Edith J. Lee  
 Address Williamsport Md  
 19. May 18 48 Edna F. Collins  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 48 8:10 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 48 to May 17 48  
 and that I last saw him alive on May 17 48

Immediate cause of death Cerebral thrombosis DURATION 2 Weeks  
 Due to Generalized arteriosclerosis 3 Yrs. History

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. Suit Ritchie M.D.  
6906 Ritchie Road SE. M. D. or other  
 Address Washington 19 D.C. Date signed May 17 1948

Birth date and birth place  
unknown. Every effort to find  
this information was made

W. S. T. T. T. M.O.

1181  
1171  
1171  
1171



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

47c 05227  
Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Forestville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43 years.Hospital, institution, or street address where death occurred:  
Brown Station Road.

How long in hospital or institution?

## 3. (a) FULL NAME

George Merton Sane.4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed.6. (b) Name of husband or wife Helen Marion Sane.7. Birth date of deceased (mo., day, yr.) December 12, 1881 6. (c) If alive, give age 48 years8. AGE: Years 66 Months 5 Days 9 If less than one day hrs. min.9. Birthplace Beland, Maryland  
(Town, county, and state)10. Usual occupation Insurance Agent11. Industry or business Insurance12. Name George Samuel Sane13. Birthplace Annapolis, Md.14. Maiden name Alice Cordella Sane15. Birthplace Forestville, Md.16. Informant Mrs. Beryl SaneAddress Forestville, AFD Upper Marlboro17. Burial Date thereof May 23, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forestville MethodistLocation Forestville, Md.18. Funeral director Rethic Bros.Address Main St. Upper Marlboro, Md.19. May 22 19 48 Edna Collins  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Forestville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Brown Station Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

597-14-9314

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 48 at 6:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 19 48 to May 21 19 48and that I last saw him alive on May 21 19 48.Immediate cause of death Bronchogenic carcinomaDURATION 6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE William Brannin M. D.Address Capitol Heights, Md. Date signed 7/21/48

MARGIN RESERVED FOR BINDING

7-1

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1310 05228 239

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Laurel, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Suddenly

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Dr. Harrow Hospital.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town Laurel, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5-34 Dal Box 217.

If rural, give LOCATION

2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

SILAS TIMOTHY DUSTIN

## 3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

JUNE 20, 1886.

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

61112

hrs.

min.

9. Birthplace

Scaggsville, Md.  
(Town, county, and state)

10. Usual occupation

Engineer - retired.

11. Industry or business

MOTHER FATHER

12. Name

SILAS R. DUSTIN

13. Birthplace

SCAGGSVILLE, Md.

14. Maiden name

MOXLEY

15. Birthplace

ELLIOTT CITY, Md.

16. Informant

RAYMOND C. DUSTIN

Address

SCAGGSVILLE, Md.

17.

Burial

Date thereof

May 1948.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

EMMANUEL METHODIST CHURCH CEM.

Location

HIGHRIDGE, LAUREL, Md.

18. Funeral director

James D. Dillies.

Address

505 Washington Blvd., Laurel, Md.

19.

May 23 1947

(Date rec'd by registrar)

M. Brachman

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 22

19

48 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

19

19

19

19

19

19

19

19

19

and that I last saw him alive on

Immediate cause of death

acute congestive heart failure  
Cardiovascular renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

M. D. or other

Address

Date signed

5-22-48

RECEIVED

MAY 27 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 yr., 3 mos., 4 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 1 yr., 3 mos., 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
1254 Half St., S. E.  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

### 3. (a) FULL NAME

GOLDEN DYSON

### 3. (b) Social Security Number

217-14-7553

4. Sex <u>Male</u>	5. Color or race <u>Negro</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	----------------------------------	---

6. (b) Name of husband or wife..... - - -

7. Birth date of deceased (mo., day, yr.) October 20, 1911  
6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
<u>36</u>	<u>36</u>	<u>6</u>	<u>20</u>	..... hrs. .... min.

9. Birthplace..... Charles County, Maryland  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... - - -

12. Name..... William A. Dyson

13. Birthplace..... Charles Co., Maryland

14. Maiden name..... Mollie Bowman

15. Birthplace..... Charles Co., Maryland

16. Informant..... Deceased

Address.....

17. Removal Date thereof..... 5-10-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... To Washington D. C.

18. Funeral director..... Malvan + Schey inc.

Address..... 424 - R - St. N. W.

19. May 10, 1948 Rowland S. Philips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 10, 1948 at 10:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5, 1947 to May 10, 1948 and that I last saw him alive on May 10, 1948

Immediate cause of death..... Pulmonary Tuberculosis DURATION 1 yr. 4 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Daniel Leo Emmecke M.D. M. D. or other

Address..... Glenn Dale, Md. Date signed..... 5/10/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05280

Reg. Dist. No. 245

### 1. PLACE OF DEATH:

County... Pr. Georges

City or town... Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
4006 - 37th St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Pr. Georges

City or town... Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

Street No... 4006 37th St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

IDA MAY ELLIS

### 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife... George D. Ellis

7. Birth date of deceased (mo., day, yr.) February 23, 1869

8. AGE: Years Months Days It less than one day

79 3 3 hrs. min.

9. Birthplace... Mt. Savage, Md.  
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... At home

12. Name... unknown

13. Birthplace... unknown

14. Maiden name... unknown

15. Birthplace... unknown

16. Informant... Mr. Miner Ellis

Address 2926 Porter St., N.W. Wash. DC

17. Burial Date thereof... May 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rock Creek Cemetery

Location... Washington, D. C.

18. Funeral director... S. H. Hines Co.

Address 2901 14th St., N.W. Wash. DC

19. May 26 19 48 Mrs. Jas. Severs Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH... MAY 26 19 48 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN 26 19 48 to MAY 26 19 48

and that I last saw her alive on MAY 25 19 48

Immediate cause of death... CONGESTIVE HEART FAILURE

DURATION 4 WEEKS

Due to... ARTERIO-SCLEROTIC HEART DISEASE 3 + yrs

Due to... ARTERIO-SCLEROSIS, GENERAL 3 + yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations... ✓

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ✓

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... L. B. Thomas M.D. M. D. or other

Address 2204 R St. N.W. Date signed 5/26/48

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 27 1948

BUREAU V. S.

05231

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Killbuck  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

6207 Brooks Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Killbuck  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6207 - Brooks Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Casper John Essig

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 31, 1879

## 8. AGE:

Years

Months

Days

If less than one day

68

hrs. min.

## 9. Birthplace

Washington DC  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

FATHER

## 12. Name

Bottlieb Essig

## 13. Birthplace

Germany

## 14. Maiden name

Elizabeth Pfeiffer

## 15. Birthplace

York, Pa

## 16. Informant

George Essig

## Address

6207 Brooks Rd, Wash DC

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

5-8-48  
(month) (day) (year)

## Cemetery or crematory

Episcopal Church

## Location

Forestville Md.

## 18. Funeral home

W. W. Chambers Co.

## Address

517 11th St S.E.

## 19.

May 6  
(Date rec'd by registrar)

19. 48

Carrie F. Campbell

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19. 48 at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 19. 47 to May 5 19. 48and that I last saw him alive on May 4 19. 48

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Brannis

M. D.

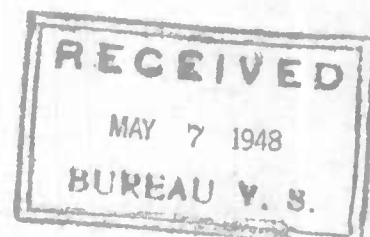
Address Capitol Heights, Md Date signed 5/5/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05232

Reg. Diat. No. 230

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Beltsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town Beltsville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ANNIE E. FLETCHER

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Charles D. Fletcher

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1873  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 7 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Warrenton, Va.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home

FATHER 12. Name Thomas Wine  
 13. Birthplace Virginia

MOTHER 14. Maiden name Lucy Hall  
 15. Birthplace Virginia

16. Informant Mr. Charles D. Fletcher  
 Address Box 28, Beltsville, Md.

17. Burial Date thereof May 10, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln Cemetery  
 Location Bladensburg Road, Md

18. Funeral director Waxner & Pumphrey, Inc.  
 Address 8434 Ga. Ave., Silver Spring, Md.

19. May 7th 1948 John D. Smith  
 (Date reg'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 - 1948 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1946 to May 6, 1948  
 and that I last saw him alive on May 6, 1948

Immediate cause of death Coronary Thrombosis  
 DURATION 1 -

Due to Hypertension  
degenerative atherosclerosis  
 Due to Sclerosis

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W.B. [Signature] M.D. or other \_\_\_\_\_  
 Address Landon Date signed 5/6/48

RECEIVED

MAY 10 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213/

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Charlestown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 day  
Hospital, institution, or street address where death occurred:

Prince Georges General Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Bowie  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Vincent Leo Flodung

### 3. (b) Social Security Number

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

single

#### 6. (b) Name of husband or wife

#### 7. Birth date of deceased (mo., day, yr.)

November 12, 1927

#### 8. AGE:

Years 20

Months \_\_\_\_\_

Days \_\_\_\_\_

If less than one day \_\_\_\_\_

hrs. \_\_\_\_\_

min. \_\_\_\_\_

#### 9. Birthplace

Bowie, Md.  
(Town, county, and state)

#### 10. Usual occupation

mechanic

#### 11. Industry or business

Automobile

#### FATHER

##### 12. Name

Vincent Flodung

##### 13. Birthplace

Bowie, Md.

#### MOTHER

##### 14. Maiden name

Madelene Mack

##### 15. Birthplace

Washington, D.C.

#### 16. Informant

Betty Flodung

##### Address

Bowie, Md.

#### 17. (Burial, cremation, or removal, Which?)

Burial

##### Date thereof

14 May 48  
(month) (day) (year)

##### Cemetery or crematory

Ascension Borne

##### Location

Bowie, Md.

#### 18. Funeral director

M. R. Selby

##### Address

Lanham, Md.

#### 19. (Date rec'd by registrar)

May 12

41

Amanda Brown  
Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

May 12 19 48 at 8:20 A.M.

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 \_\_\_\_\_, to 19 \_\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_.

#### Immediate cause of death

Cerebral compression

#### Due to

Cerebral edema

#### Due to

Fracture of base of skull

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op. \_\_\_\_\_

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-9-48

Where did injury occur? Mitchellville, Md. (City or town) P. 15 (County) Prince Georges (State)

Injured at home, farm, industry, public place (where?) Defense Highway

Means of injury Car Injured at work? Yes

Reported Medical Examiner

#### 23. SIGNATURE

James I. Forestall M. D. or other

Address Forestall, Md. Date signed 5-12-48

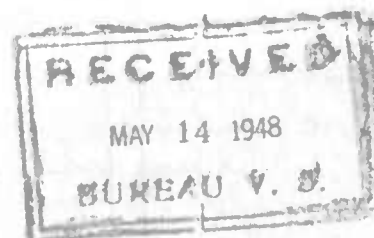
MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

242

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Danham Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town Danham Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4th & telegraph Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Elbert Edwards Fordham Jr

## 3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Sarah Fordham

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.)

April 17, 1908

8. AGE:

40

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

Alexandria Virginia

(Town, county, and state)

10. Usual occupation

Auto mechanic

11. Industry or business

FATHER

12. Name

Elbert Edwards Fordham Sr

13. Birthplace

Kenston North Carolina

14. Maiden name

Grace Allen

15. Birthplace

Nokesville Virginia

16. Informant

Edward Edwards Fordham Sr

Address

15 E Chapman St Alexandria Va

17.

Burial

Date thereof

May 25, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Dry Hill

Location

Alexandria Va

18. Funeral director

F. Cascha some

Address

Hyattsville Md

19.

May 23

19

48 Mrs Jack Bennett

(Date read by registrar)

D.L. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1948 19... at 4 P M M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19... 10... 19...

Immediate cause of death

hemorrhage due to  
shock  
from shot wound  
of the head

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, in the following:

Accident, suicide, or homicide homicide Date of 5-22

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Heater in head water pipe

Heater in head water pipe

23. SIGNATURE

M. D. of other

Address

Date signed 5-22-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

742

05235 245-  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County... Prince George's  
City or town... Riverdale  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 hours  
Hospital, institution, or street address where death occurred:  
Belmont Memorial Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Prince George's  
City or town... Beltsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... Baltimore Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Edward Saras Furr

### 3. (b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Single

#### 6. (b) Name of husband or wife

#### 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1908

#### 8. AGE:

Years 40

Months

Days

If less than one day

hrs. min.

#### 9. Birthplace

Staunton, Va.  
(Town, county, and state)

#### 10. Usual occupation

Unemployed

#### 11. Industry or business

#### 12. Name

John Newton Furr

#### 13. Birthplace

Virginia

#### 14. Maiden name

Margaret Parnell

#### 15. Birthplace

Virginia

#### 16. Informant

Rube Furr

#### Address

Beltsville Md

#### 17.

Rural

Date thereof 5-5-48  
(month) (day) (year)

#### Cemetery or crematory

Geo. Wash. Mem Park

#### Location

Riggs Rd. Hyattsville, Md

#### 18. Funeral director

W.W. Hankins & Co.

#### Address

Riverdale, Md  
May 4 48 James Servis

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

May 3 1948 at 6:00 AM

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

#### Immediate cause of death

Acute nasal hemorrhage  
Due to Chronic leukemia  
leucemia

#### DURATION

#### Due to

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

#### Accident, suicide, or homicide

#### Where did injury occur?

Injured at home, farm, industry, public place (where?)

#### Means of injury

Injured at work?  
Heavy medical equipment

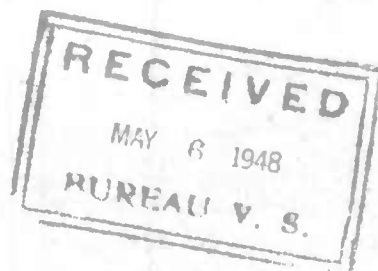
#### 23. SIGNATURE

Address... Beltsville Md Date signed 5-3-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

830 05236 245  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Arundale, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Arundale, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2002 - Woodruff Road.  
(If rural, give LOCATION)2.(a) If veteran, name war 1st World War. Navy.

## 3. (a) FULL NAME

George Fitch Gardner

## 3. (b) Social Security Number

5-79-16-4535Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Cecil Dublin Gardner7. Birth date of deceased (mo., day, yr.) Dec 3, 1891 6.(c) If alive, give age 50 years8. AGE: Years 56 Months 5 Days 27 If less than one day hrs. min.9. Birthplace Charlottesville, S.C.  
(Town, county, and state)10. Usual occupation Construction Engineer

11. Industry or business

12. Name Christopher Pendleton13. Birthplace New London, Conn.14. Maiden name Louisa Cilinda Rogers15. Birthplace New Roch. Conn.16. Informant Cecil Dublin GardnerAddress 2002 - Woodruff Rd. Arundale17. Burial Date thereof 6-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington Virginia18. Funeral director The S. H. Hines Co.Address 2901 - 14th St. N.W. Washington D.C.Date May 30 1948 James Sevey Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 30 1948 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Sudden Cerebral HemorrhageDue to Arterial hypertensionDue to 15 years.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Maloney, M.D. Deputy Med. ExamAddress Chesley, Hyattsville, Md. Date signed 5-30-48

M.D. or other

RECEIVED

JUN 1 1948

BUREAU V. B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 15237

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 19 years  
Hospital, institution, or street address where death occurred: 5601-1 Penning Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5601-1 Penning Road  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Emma Margaret Good

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife James E. Good  
6. (c) If alive, give age 38 years  
7. Birth date of deceased (mo., day, yr.) December 17, 1873  
8. AGE: Years 74 Months - Days - If less than one day - hrs. - min.

9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business  
12. Name David Frank  
13. Birthplace Virginia  
14. Maiden name Margaret Mason  
15. Birthplace Virginia

16. Informant Ruby Spear  
Address 805-57th Ave Capitol Hill  
17. Burial Date thereof May 27, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Cedar Hill  
Location Spittland Md

18. Funeral director Real Funeral Home  
Address 4812 Edgewood Ave Wash DC

19. May 25 1948 Carrie F. Campbell  
(Date reg'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 145  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
and that I last saw h..... alive on 19

Immediate cause of death Coronary occlusion  
Due to cardiovascular renal disease  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, pub'c place (where?)  
Means of injury Injured at work  
23. SIGNATURE Shepherd M. D. or other  
Address..... Date signed May 27

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of birth date shown on:

RUM No. G 116 JUN -2 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince George's

City or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

7220 Oxon Hill Road

How long in hospital or institution?

## 3. (a) FULL NAME

Rosa Melvinia Green

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John Green

7. Birth date of deceased (mo., day, yr.)

February 24, 1876

8. AGE:

Years

Months

Days

It less than one day

72

hrs.

min.

9. Birthplace

Oxon Hill, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Wilson Green

13. Birthplace

Maryland

MOTHER

14. Maiden name

Caroline Jones

15. Birthplace

Maryland

16. Informant

Josephine Jones

Address

7220 Oxon Hill Road, Oxon Hill, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 11 - 48  
(month) (day) (year)

Cemetery or crematory

St. Paul M. E. Church Cemetery

Location

Oxon Hill, Md.

18. Funeral director

Robert S. McGuire

Address

1820 - 9 St N.W.

19. May 20

(Date rec'd by registrar)

19 48

Carrie F. Campbell

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7220 Oxon Hill Road

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1948 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute congestive heart failure

DURATION

Due to

Cardiovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Repaty medical Gayner

23. SIGNATURE

M. D. or other

Address 7220 Oxon Hill Road Date signed 5-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05239 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 10 mos., 15 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 10 mos., 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 5101 Nevada Avenue, N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

THOMAS VINCENT GRIFFITH

## 3. (b) Social Security Number

---

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Margaret Griffith  
 7. Birth date of deceased (mo., day, yr.) January 13, 1904  
 6.(c) If alive, give age 42 years  
 8. AGE: Years Months Days If less than one day  
 44 44 4 7 hrs. min.

9. Birthplace Phillipsburg, New Jersey  
 (Town, county, and state)  
 10. Usual occupation Lawyer  
 11. Industry or business  
 12. Name David Griffith  
 13. Birthplace Wales, England  
 14. Maiden name Kathryn Bowers  
 15. Birthplace Stewardsville, New Jersey

16. Informant Deceased  
 Address  
 17. Removal Date thereof 5/20/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Washington D. C.  
 Location The 65th St. Co.  
 18. Funeral director The 65th St. Co.  
 Address 2901-14th St NW.  
 19. May 20, 48 T Rowlands S. Phillips Registrar  
 (Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1948 at 6:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1947 to May 20 1948  
 and that I last saw him alive on May 20 1948

Immediate cause of death Pulmonary Tuberculosis  
 DURATION 5 yrs 5 mo

Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucan MD.  
 M. D. or other  
 Address Glenn Dale, Md. Date signed 5/20/48

RECEIVED

MAY 27 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942 05240

FILM No. G 11, MAY 18 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges Hosp.  
City or town Chesley Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 minutes  
Hospital, institution, or street address where death occurred:  
Prince Georges Hosp.  
How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Prince Georges  
City or town Calmar Manor  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3703 - Bladensburg Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Gilberti, Mr. Giuseppe

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 May 1948 19 48 at 6:55 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec 3 19 47 to May 8 19 48  
and that I last saw him alive on May 8 19 48

Immediate cause of death

Coronary Occlusion

DURATION

Due to Coronary Insufficiency  
E.K.G. Nov. 18. 47

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. H. Norton M. D. or other  
Address 3827-34 St Mt Rainier Date signed Apr 8 47

11. Industry or business

Retired

12. Name

Michael Gilberti

13. Birthplace

Italy

14. Maiden name

Salvatore Vendemia

15. Birthplace

Italy

16. Informant

W. F. C.

Address

Same as above

17. Burial

May 11, 1948

(Burial, cremation, or removal. Which?)

St. Lincoln

Cemetery or crematory

Washington St. C.

18. Funeral director

F. Christie son

Address

Hyattsville Md.

19.

5/10 48

Amanda Deuney

(Date rec'd by registrar)

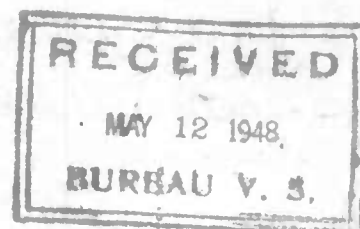
Registrar

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 12 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1572

05241

231

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

19.

Amanda H. Hoxey

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 9

19.

48 at 10<sup>00</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-9-48

19.48

to 5-9-48

19.48

and that I last saw her..... alive on

5-9-48

19.48

Immediate cause of death.....

Failure of respiration  
arteries due to collapse of  
skull done to accomplish  
delivery of a hydrocephalic  
infant

Due to.....

Due to.....

DURATION

Other conditions.....

Spina bifida  
Clubbed feet  
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Francis Warner, M.D.

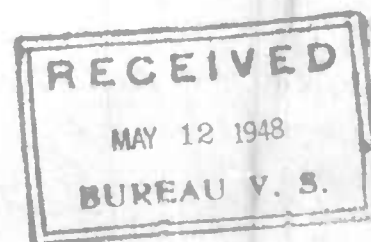
M. D. or other

Address.....

1746 - K. N. H. W.

Date signed.....

5/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

## 1. PLACE OF DEATH:

County Prince George's CountyCity or town Bladensburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 YEARS

Hospital, institution, or street address where death occurred:

4510 BALTIMORE AVE

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Bladensburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4510 Baltimore Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ELIZABETH WILHELMIA DWYER HAGE

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife NELS HAGE4510 BALTIMORE AVE 6. (c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) MARCH 14 1864

8. AGE:

Years

Months

Days

If less than one day

84218

hrs.

min.

9. Birthplace Abbingt. n. Hartford Md.  
(Town, county, and state)10. Usual occupation house wife

11. Industry or business

FATHER

12. Name

ALBERT DWYER

13. Birthplace

HARTFORD County Md.

14. Maiden name

Elizabeth Pritchard

15. Birthplace

England16. Informant MRS. MARIE WALLACE

Address

4510 BALTIMORE AVE17. Burial  
(Burial, cremation, or removal) Which?Date thereof June 1, 1948  
(month) (day) (year)

Cemetery or crematory

Wilmington National

Location

Wilmington, Va.18. Funeral director Shoichi Sano

Address

Hyattsville, Md.19. 5/28 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 48, at 9 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48 to May 22 19 48and that I last saw him alive on May 25 19 48

Immediate cause of death

Myocardial infarction

DURATION

Due to

Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

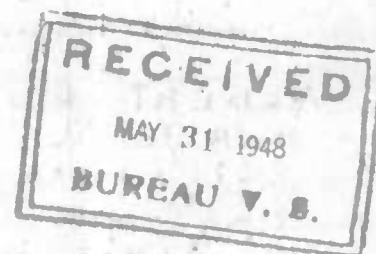
Injured at work?

23. SIGNATURE

Albert L. Wall

M. D. or other

Address Hyattsville, Md. Date signed 5/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

164e

05243

245

Reg. Dist. No. ....

## 1. PLACE OF DEATH: Prince Georges

County.....

City or town..... Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince Georges

City or town..... Mt. Rainier Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 4308 Russell Street  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Gerald Edwin Harris

## 3. (b) Social Security Number

4. Sex.....

male

5. Color or race.....

white

6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife..... Cora Eleanor Harris

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... August 8, 1917

8. AGE: Years..... Months..... Days..... If less than one day

30

..... hrs. .... min.

9. Birthplace..... Colorado  
(Town, county, and state)

10. Usual occupation..... tree surgeon

11. Industry or business.....

12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... Unknown

16. Informant..... Cora Eleanor Harris

Address..... Mt. Rainier Md.

17. Burial..... Date thereon..... May 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Lincoln Cemetery

Location..... Washington D. C.

18. Funeral director..... F. Gasch's Sons

Address..... Hyattsville Maryland.

19. May 21, 1948..... Mrs. Joe Severed  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 18, 1948, at 9:20 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Hemorrhage and shock

DURATION

Due to..... Gun shot wound of

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide Date of..... 5-18-48

Where did injury occur..... Mt. Rainier Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Home

Means of injury..... Shot self through head with a 22 cal. rifle

Report made by..... Deputy Medical Examiner

23. SIGNATURE..... J. J. Severed M. D. or other

Address..... Bethesda Md. Date signed..... 5-19-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:  
 County Prince George's  
 City or town Capital Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Transient  
 Hospital, institution, or street address where death occurred:  
6310 Central Ave.,  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town Capital Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 424 59th Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3.(a) FULL NAME

Solomon George Hebelor

### 3.(b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Julia Hebelor  
 7. Birth date of deceased (mo., day, yr.) February 7, 1887  
 8. AGE: Years 61 Months  Days  It less than one day   
 (c) If alive, give age 61 years

9. Birthplace Clarence Center, N. Y.  
 (Town, county, and state)  
 10. Usual occupation Photographer  
 11. Industry or business

12. Name John Hebelor  
 13. Birthplace N. Y.  
 14. Maiden name Magdalena Gaser  
 15. Birthplace N. Y.

16. Informant Mrs. Julia Hebelor  
 Address 424 59th Ave., Capital Heights  
 Date thereof May 24, 1948  
 (Month) (day) (year)

Cemetery or crematory Batavia  
 Location New York  
 18. Funeral director F. Gaschi sons  
 Address Hyattsville Md.

19. 5/24 19 48 Amanda Howney  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1948 at 12:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
 and that I last saw him alive on 19

Immediate cause of death Acute congestive heart failure

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James M. D. or other

Address Forestville, Md. Date signed 5/22/48

MARGIN RESERVED FOR BINDING

21

9-45-15W

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1948

BUREAU V. R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 950 05245 245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgeCity or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4513 Banner st.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louise Dorsey Holmes

## 3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorcedWidowed6. (b) Name of husband Jack Holmes

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-18688. AGE: Years 79 Months 10 Days 21 If less than one day  
hrs. min.9. Birthplace Washington D.C.  
(town, county, and state)10. Usual occupation dress maker

11. Industry or business

12. Name Henny Dorsey13. Birthplace Washington, D.C.14. Maiden name Ann Beal15. Birthplace Washington, D.C.16. Informant Aline Ray TolsonAddress 4513- Banner st. N.W.17. removal Date thereof May 28 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hormans CemeteryLocation 801-R. I. ave. N.E. Wash. D.C.18. Funeral director Robert E. SmeckAddress 1820-9 St. N.W.19. 5/24 19 48 Amanda Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 48 at 4: A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 48 to May 23 19 48  
and that I last saw him alive on May 23 19 48Immediate cause of death Cardiac failure  
Heart disease  
Due to High Blood Pressure

## DURATION

2 wks7 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W.S. Hudson, M.D. M. D. or otherAddress Laurel Md Date signed May 24/48

1968  
66  
1961

1948-8-24  
1948-7-3  
1948-10-21

RECEIVED  
MAY 27 1948  
BUREAU V. S.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**  
date shown on: 2411 N. Charles St., Baltimore

05246

FILE No. G 116 AUG 4 - 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:  
County *Pro Geo Co*  
City or town *Forestville Md*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State *Md* County *Pro Geo*  
City or town *Forestville Md*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *walker mill Rd*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME *William M. Howland*

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W* 6.(a) Single, married, widowed, or divorced *widowed*

6.(b) Name of husband or wife *susan F. Howland*

7. Birth date of deceased (mo., day, yr.) *Dec 6, - 1875* 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
*72 73 5 19* hrs. min.

9. Birthplace *N.Y.*  
(Town, county, and state)

10. Usual occupation *machinist - Retired*

11. Industry or business *Navy yard - unknown*

12. Name *scotland*

13. Birthplace *unknown*

14. Maiden name *scotland*

15. Birthplace *Robert A. Howland*

16. Informant *10315 Crestmont drive*

17. Burial *St. Lincoln* Date thereof *June 3, 1948*  
(month) (day) (year)

Cemetery or crematory *Colmar Manor Md*

Location *Forestville Md*

18. Funeral director *6/3 48 Amanda Downey*

Address *Forestville Md*

19. (Date rec'd by registrar) *6/3 48* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *About May 25 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19* to *19* and that I last saw him alive on *19*

Immediate cause of death *Many weeks dead about 1 week before found.*

Due to *Chronic renal disease*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

23. SIGNATURE *John D. Maloney MD* *Examiner*  
Address *Cherry Hill Md* Date signed *6-2-48*

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 159 05247 232  
 Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....Pr. Geo  
 City or town.....Rural Mitchellville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....Life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....md County.....Pr. Geo  
 City or town.....Rural Mitchellville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....1/2 north Hall's Crossing  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

JOSEPH JASPER  
Infant Boy James

## 3. (b) Social Security Number

4. Sex.....M 5. Color or race.....C 6. (a) Single, married, widowed, or divorced.....Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....May 25, 1948 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min. 2

9. Birthplace.....Mitchellville Pr. Geo Md  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....Frank A James  
 13. Birthplace.....Pr. Geo Co.

MOTHER 14. Maiden name.....Mathe V. Owens  
 15. Birthplace.....Pr. Geo Co.

16. Informant.....Frank A James  
 Address.....Mitchellville Md 34

17. Burial Date thereof.....May 27, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Antioch, Md  
 Location.....Mitchellville, Md

18. Funeral director.....J. B. Johnson  
 Address.....Baltimore

19. May 27, 48 19.....Reynolds  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 27 19.....48, at.....6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....25 May 19.....48, to.....27 May 19.....48  
 and that I last saw him.....alive on.....27 May 19.....48

Immediate cause of death.....Atelactasis

Due to.....Prematurity

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

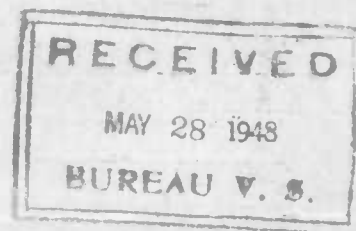
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....Robert B. Sasser M. D. asst  
 Address.....Upper Marlboro, Md Date signed.....27 May 48



*[Faint, illegible handwritten text, possibly a signature or initials]*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

EVIDENCE FOR ADDITION OF AGE.

D. QUES. 6, 8, 7, 8, 10, 11, 12, 13, 14, 15, +16 2411 N. Charles St., Baltimore

AND CHANGE OF #17 SHOWN ON:

FILE No. 6 116 JUNE 1 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Cheverly, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... R.A.

City or town..... Drury Post Office

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Melvin Jenkins

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

M

W

Married

6.(b) Name of husband or wife..... EDNA WALTON

7. Birth date of deceased (mo., day, yr.)..... JULY 12, 1909

6.(c) If alive, give age..... years

8. AGE: Years..... 38 Months..... 10 Days..... 14 If less than one day..... hrs. .... min.

9. Birthplace..... Nutwell, Md

(Town, county, and state)

10. Usual occupation..... CARPENTER

11. Industry or business..... HOUSE BUILDING

12. Name..... THEODORE JENKINS

13. Birthplace..... NUTWELL, MD.

14. Maiden name..... EFFIE RODGERS

15. Birthplace..... DEALE, MD.

16. Informant..... THEODORE JENKINS

Address..... DRURY, MD.

17. Burial..... Date thereof..... May 29, 1948

(Burial, cremation, or removal, Which?)..... (month) (day) (year)

Cemetery or crematory..... ST. JAMES

Location..... TRACY'S HANDLING

18. Funeral director..... T. A. Hurdleasty &amp; Son

Address..... Guilfordville, Va

19. 5/27 48 Amanda Dourney

(Date rec'd by registrar)..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 26 19 48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 May 19 48 to 26 May 19 48 and that I last saw him alive on 26 May 19 48

Immediate cause of death..... Cerebral Vascular Accident

## DURATION

10 days

Due to..... Wink

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert B. Sasser

M. D. coauthor

Address..... Upper Marlboro, Md Date signed 22 May 48

RECEIVED

MAY 28 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05249  
Reg. Dist. No. 243

1. PLACE OF DEATH:  
County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 8 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 1 month, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 1317-22nd Street, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
VASSAR. JOHNS

3. (b) Social Security Number  
709-12-4816

4. Sex Male  
5. Color or race colored  
6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife..... Adeline Johns  
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 10, 1903

8. AGE: Years Months Days If less than one day  
44 44 8 21 hrs. min.

9. Birthplace..... Farmville, Virginia  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... Carter Johns

13. Birthplace ? Virginia

14. Maiden name..... Lizzie Price

15. Birthplace ? Virginia

16. Informant..... Deceased

Address.....

17. Removal to Wash. D.C. 5 1 48  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address 389-17th St. N. W.

51 48 Rowland S. Philips

19. (Date rec'd by registrar) 5/1/48 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 1948 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1948 to May 1st 1948 and that I last saw him alive on May 1st 1948

Immediate cause of death Pulmonary Tuberculosis

#### DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Lincane MD

M. D. or other

Address Glenn Dale, Md. Date signed 5/1/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 225 15250

## 1. PLACE OF DEATH:

County..... **Prince George's**  
 City or town..... **Upper Marlboro, Md**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **Transient**  
 Hospital, institution, or street address where death occurred:  
**Route 301**  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **New York** County.....  
 City or town..... **Syracuse**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **105 Glenwood**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **U.S. MARINES** ✓

## 3. (a) FULL NAME

**Earl W. Johnston Jr.**

## 3. (b) Social Security Number

4. Sex..... **Male**  
 5. Color or race..... **White**  
 6.(a) Single, married, widowed, or divorced..... **Single**  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... **December 14, 1927**  
 8. AGE: Years..... **20** Months..... Days..... It less than one day..... hrs. .... min.

9. Birthplace..... **Syracuse, N. Y.**  
 (Town, county, and state)  
 10. Usual occupation..... **U. S. Marines**  
 11. Industry or business.....  
 FATHER 12. Name..... **Earl W. Johnston Sr.**  
 13. Birthplace..... **New York**  
 MOTHER 14. Maiden name..... **Gertrude MacDonald**  
 15. Birthplace..... **New York**

16. Informant..... **Carl Ballweg**  
 Address..... **4612 S. Salina St., Syracuse N. Y.**  
 17. Burial..... **Burial** Date thereof..... **5/29/48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... **St. Agnes Cemetery**  
 Location..... **Syracuse, New York**  
 18. Funeral director..... **W.W. Hanks Co**  
 Address..... **Prindale, Md**  
 19. **May 29** 19 **48** **Mrs. Jas. Severe**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May** **29** 19 **48** at **12:12 A**

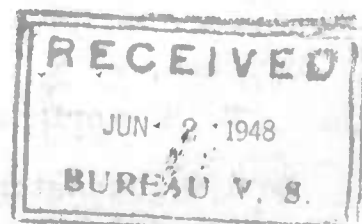
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....  
**Hemorrhage and shock**  
 Due to..... **Fracture of the skull**  
**Crushed chest**  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... **Accident** Date of..... **5/29/48**  
 Where did injury occur? **Upper Marlboro P. G. Md.**  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) **Route 301**  
 Means of injury..... **Driver of a car in a collision**  
 Deputy Medical Examiner.....  
 23. SIGNATURE..... **James H. Ford** M. D. or other  
 Address..... **Forestville, Md.** Date signed..... **5/29/48**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05251

Reg. Dist. No. 245

### 1. PLACE OF DEATH:

County Prince Georges  
City or town High Bridge, Bowie  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town High Bridge, Bowie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Clara Huddle Jones

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Richard D. Jones  
7. Birth date of deceased (mo., day, yr.) July 13, 1869 8. (c) If alive, give age 75 years  
8. AGE: Years 78 Months 10 Days 1 If less than one day  
hrs. min.

9. Birthplace Worthington, Ohio  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Own home  
12. Name Clara Huddle Jones  
13. Birthplace Ohio  
14. Maiden name Catherine Brown  
15. Birthplace Ohio

16. Informant Mrs. Catherine Larson  
Address High Bridge, Bowie, Md  
17. Burial Date thereof 5-18-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Wash. Natl  
Location Secluded part  
18. Funeral director W. W. C. Hauler & Co  
Address Princeton, Md  
19. May 15 19 48 Mrs. Jas. Severel  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 48 at 10 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 19 39 to May 14 19 48  
and that I last saw him alive on May 14 19 48

Immediate cause of death Pulmonary haemorrhage  
Due to Bronchectasis  
Due to  
Other conditions

DURATION  
10 min  
4 years

(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Robert J. McCreary  
402 N. Main St. Laurel, Md. M. D. or other  
Address Date signed 5/14/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WR. ONLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1948

BUREAU V. A.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 97

Reg. Dist. No. 230

1. PLACE OF DEATH: PRINCE GEORGES  
 County.....  
BELTSVILLE, Md.  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? LIFE  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
PRINCE GEORGES  
 State..... County.....  
BELTSVILLE  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME J. SIMMS JONES

3. (b) Social Security Number  
 —

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced SINGLE.  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) MARCH 24, 1872. 8. AGE: Years 76 Months 2 Days 5 If less than one day  
 ..... hrs. .... min.

9. Birthplace BELTSVILLE, Md.  
 (Town, county, and state)  
 10. Usual occupation GEN. INSURANCE AGENT.  
 11. Industry or business OWN BUSINESS.  
 12. Name HENRY C. JONES.  
 13. Birthplace WILMINGTON, DEL.  
 14. Maiden name ELIZABETH SIMMS.  
 15. Birthplace CLARKSVILLE, Md.  
 16. Informant MISS SARAH E. JONES.  
 Address BELTSVILLE, Md.

17. BURIAL Date thereof JUNE 1, 1948.  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory ST. JOHN'S CHURCH CEMETERY.  
BELTSVILLE, Md.  
 Location.....  
 18. Funeral director J. ARTHUR WALTERS.  
 Address 505 WASHINGTON BLVD., LAUREL, Md.  
 19. MAY 31<sup>ST</sup> 1948 John D. Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 29, 1948 at 4:42 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 28 1948 to 5/29 1948  
 and that I last saw him alive on MAY 29 1948

Immediate cause of death  
arteriosclerosis  
hypertension

DURATION

1948

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

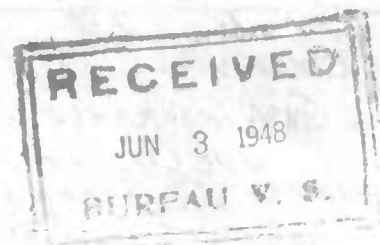
23. SIGNATURE John D. Smith M. D. or other  
 Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05253243  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Prince Georges  
City or town... Glenn Dale, Md., (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 months, 13 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 4 months, 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... D.C. County...  
City or town... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2226- Nicholas Ave., S.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

## 3. (a) FULL NAME

KARR FULTON, B

## 3. (b) Social Security Number

none

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

-

## 7. Birth date of deceased (mo., day, yr.)

December 2, 1873

## 8. AGE:

Years

Months

Days

If less than one day

74

5

28

hrs.

min.

## 9. Birthplace

Frostburg, Md.

(Town, county, and state)

## 10. Usual occupation

musician

## 11. Industry or business

-

FATHER  
MOTHER

## 12. Name

Watson Karr

## 13. Birthplace

Dayton, Ohio.

## 14. Maiden name

Mary Dilley

## 15. Birthplace

Cumberland, Md.

## 16. Informant

deceased

## Address

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

6 1 48  
(month) (day) (year)

## Cemetery or crematory

Cedar Hill Cemetery

## Location

Landover, Prince Georges Co., Md.

## 18. Funeral director

Samson Bros. Funeral Home

## Address

2007- Nichols Ave S.E.

## 19.

5/14 48  
(Date rec'd by registrar)Rowland S. Phillips  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 29, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/16 1948 to 5/29 1948  
and that I last saw him alive on 5/29 1948

Immediate cause of death

pulmonary tuberculosis

DURATION

5 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Daniel Leo Finneas MD  
Glenn Dale, Md. Date signed 5/29/48

**RECEIVED**

JUN 12 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4625434

## 1. PLACE OF DEATH:

County Frederick  
 City or town Clinton  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Anna Virginia Lake.

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife William S. Lake.

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1855  
 6. (c) If alive, give age..... years

8. AGE: Year 93 Months 4 Days 13 It less than one day  
 hrs. min.

9. Birthplace Gapville, Penna.  
 (Town, county, and state)

10. Usual occupation at home

## 11. Industry or business

12. Name William Samuel Leddage  
 13. Birthplace Ireland

14. Maiden name Sarah Frayer  
 15. Birthplace Bedford Co., Penna.

16. Informant Boyd M. Lake  
 Address Clinton, Md.

17. Burial Date thereof 5-30-48  
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Pleasant Grove  
 Location Clinton Co. Penna.

18. Funeral director Wilbur Lipes  
 Address Salubra, Penna.

19. 5-27 48 Mrs. Eldon Davis  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County P. Sta.  
 City or town Clinton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1948 at 2:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to May 26 1948 and that I last saw him alive on May 25 1948

Immediate cause of death Carcinoma of Stomach DURATION 1 year

Due to .....

Due to .....

Other conditions Arteriosclerosis 20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Sasser M. D. or other  
 Address Upper Marlboro, Md. Date signed 5-26-48

RECEIVED

MAY 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05255

245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town North Woodridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

4624-21 st St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town North Woodridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4624-21

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George W Lee

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Marie V Lee

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1-1856

8. AGE:

Years

Months

Days

If less than one day

9231

hrs.

min.

9. Birthplace England  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant Mrs Marie L. PortchAddress 4624-21 St. North Woodridge Md.17. Burial  
(Burial, cremation, or removal. Which?)Date thereof May 5-1948  
(month) (day) (year)Cemetery or crematory St. LincolnLocation Wash - Balto Blvd + D. L. Line Md.18. Funeral director Wm. J. MalleyAddress 3200 St. J. Ave. Mt Rainier Md.19. May 4 1948  
(Date rec'd by registrar)Mrs. Jan. Devere  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1948 at 7: A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1947 to May 2 1948  
and that I last saw h. l. m. alive on April 30 1948

Immediate cause of death

Senility  
Age in gradual failing health.

Due to

Due to InanitionWould not eat

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

X. Charles Duraci M.D.  
620- Upshur St N.W.

M. D. or other

Date signed 5/2/48

RECEIVED

MAY 6 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

520

## CERTIFICATE OF DEATH

Reg. Dist. No. 05256 239

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:

Warren's HospitalHow long in hospital or institution? 3 weeks

## 3. (a) FULL NAME

Joseph Edgar Linzey4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Sarah T. Linzey6. (c) If alive, give age 44 years7. Birth date of deceased (mo., day, yr.) July 22, 18758. AGE: Years 72 Months 9 Days 18 It less than one day hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Retired bookbinder

11. Industry or business

12. Name William W. Linzey13. Birthplace Towson, Baltimore Co. Md.14. Maiden name Sarah H. Baker15. Birthplace Baltimore, Maryland16. Informant Mr. W. C. SippleAddress Laurel, Maryland17. Burial Date thereof May 12, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hart Lincoln CemeteryLocation Bladenburg Rd., Md.18. Funeral director De Witt DonaldsonAddress Laurel, Maryland19. May 11 19 48 M. Brashears  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 Washington Avenue  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10-48 19 48 at 12:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-16-48 19 48 to 5-10-48 19 48and that I last saw him alive on 5-10-48 19 48Immediate cause of death Acute Cardiac  
DehydrationDURATION 1 dayDue to Pyelonephritis 3 yrsDue to peptic ulcer 2 yrsOther condition urineCarcinoma of Kidney

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Carcinoma of Kidney

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

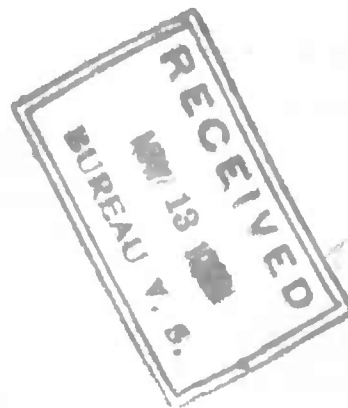
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE B. P. Warner M. D. or otherAddress Rural Md. Date signed 5-10-48







RECEIVED

MAY 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

05258

Reg. Dist. No. 240

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Beltz Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
1013-64-ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Beltz Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1013-64-ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James Lynch.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Mary H. Lynch  
Feb 10<sup>th</sup>

7. Birth date of deceased (mo., day, yr.) FEB. 10<sup>th</sup> 1886 8.(c) If alive, give age 60 years

8. AGE: Years 60 Months 2 Days 24 If less than one day  
 .....hrs. ....min.

9. Birthplace Lynchburg, Va.  
 (Town, county, and state)

10. Usual occupation Laborer (Doorman)

11. Industry or business U.S. Treasury

12. Name Anthony Lynch

13. Birthplace Lynchburg, Va.

14. Maiden name Susan Clements

15. Birthplace Lynchburg, Va.

16. Informant Mary H. Lynch (wife)

Address 1013-64-ave Beltz Heights

17. Removal Date thereof May 4, 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director Malver J. Sekey

Address 424 R-St. N.E.

19. May 4 1948 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1948 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1948 to May 4 1948 and that I last saw him alive on May 4 1948

Immediate cause of death Cerebral Hemorrhage DURATION ?

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

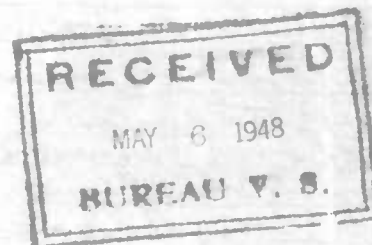
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE H.C. Beckon, M.D. M.D. or other  
W.E. 3-Hurst Pl. R.R. Date signed May 4, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Riverdale Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 hours, 35 min  
 Hospital, institution, or street address where death occurred:  
Belmont Memorial Hospital  
 How long in hospital or institution? 4 hours 35 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Berwyn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9066 Baltimore Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Fred. A. Madison

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Lily May Madison  
 6. (c) If alive, give age 64 years  
 7. Birth date of deceased (mo., day, yr.) Oct 2, 1882  
 8. AGE: Years 65 Months 6 Days 12 If less than one day  
 hrs. min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)

10. Usual occupation Food Broker

## 11. Industry or business

12. Name James A. Madison  
 13. Birthplace Madison Co. Va.

14. Maiden name Annie Goddard  
 15. Birthplace Washington, D.C.

16. Informant Mrs. Madison (son)

Address 9066 Baltimore Blvd, Berwyn

17. Burial Date thereof May 18, 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Belvidere Road N.E.

18. Funeral director William Lee Sons Co.

Address 3004th St N.E. D.C.

19. May 14 1948 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1948, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12 1948 to May 18 1948

and that I last saw him alive on April 18 1948

Immediate cause of death Pulmonary Edema

Due to Coronary heart failure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. Allen Griffith

Address Berwyn Md

Date signed 5/18/48

RECEIVED

MAY 17 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

552

05260

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH

County *Pro George's*  
City or town *Cherry Hill*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *9 months*  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Md* County *Pro Geo*  
City or town *Cherry Hill*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *5901 Forest Road*  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

*Florence Maxwell*

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*Female white Widowed*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

*Feb 18, 1859*

8. AGE: Years Months Days If less than one day  
*89* hrs. min.

9. Birthplace *New York*  
(City, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *James Upton*

12. Name *new York*

13. Birthplace *unknown*

14. Maiden name *new York*

15. Birthplace *Ira Fay Thornburgh*

16. Informant *Cherry Hill Md*

17. *Cremation* Date thereof *May 19, 1948*  
(Manner of disposal, cremation, or other) (City or town) (County) (State) (day) (year)

Cemetery or crematory *Cedar Hill*

Location *Suitland Md*

18. Funeral director *F Gasche's sons*

Address *Hyattsville Md*  
*5/19/48* *Ananda Downey*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *May 18, 1948 12:45 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 1947* to *May 18 1948*

and that I last saw him alive on *Feb 10 1948*

Immediate cause of death *Malignancy*  
*Salivary gland (Sub Maxillary)*  
*Carcinoma*

### DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE *Dayton O. Watkins MD*  
*5306 Annapolis Rd, Hyattsville Md*  
Address Date signed *5-18-48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **243**

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 24 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 519 L. Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

McCLORIN LOU ANNA

### 3. (b) Social Security Number

579-26-8704

4. Sex..... Female  
5. Color or race..... Negro  
6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Henry McClorin

7. Birth date of deceased (mo., day, yr.)..... December 19, 1916  
6. (c) If alive, give age..... 38 years

8. AGE: Years..... 31 Months..... 5 Days..... 4 It less than one day..... hrs. .... min.

9. Birthplace..... Kingstreet, South Carolina  
(Town, county, and state)

10. Usual occupation..... Laundress

11. Industry or business.....

12. Name..... John Staggers

13. Birthplace..... Kingstreet, South Carolina

14. Maiden name..... Mary Montgomery

15. Birthplace..... Kingstreet, South Carolina

16. Informant..... Deceased

Address.....

17. Removal Date thereof..... 5/25/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Washington D.C.

18. Funeral director..... St. Joseph Funeral Home

Address..... 306 1/2 St. N.W.

19. May 25, 1948 Registrar..... Rowland S. Philips

(Date rec'd by Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 23, 1948 at 5:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/28 19 48 to 5/23 19 48 and that I last saw h..... alive on 5/23 19 48

Immediate cause of death..... pulmonary tuberculosis  
DURATION..... 6 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Piusane MD

M. D. or other.....

Address..... Glenn Dale Md. Date signed..... 5/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 3 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *832* *05262* *22A*

### 1. PLACE OF DEATH:

County *Prince George's*  
City or town *Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *35 years*  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Maryland* County *Prince Georges*  
City or town *Hyattsville Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *4100 Emerson St*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

*Annie V. Moffat*

### 3. (b) Social Security Number

4. Sex *female* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *married*  
6.(b) Name of husband or wife *Herbert J. Moffat*  
7. Birth date of deceased (mo., day, yr.) *Sept 19, 1873.* 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years *74* Months *7* Days *16* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Delaware*  
(Town, county, and state)  
10. Usual occupation *Housewife*  
11. Industry or business  
12. Name *William J. Spicer*  
13. Birthplace *Delaware*  
14. Maiden name *Emily Wiley*  
15. Birthplace *Delaware*

16. Informant *Herbert J. Moffat*  
Address *Hyattsville Md.*  
17. Burial *Burial* Date thereof *May 7, 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory *Evergreen Cemetery*  
Location *Bladensburg Md.*  
F. Gasch's Sons  
18. Funeral director *Hyattsville Maryland.*  
Address

19. *May 7* 19 *48* *James Serup* Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

*May 4, 1948*

20. DATE OF DEATH \_\_\_\_\_ 19 \_\_\_\_\_ at *10:30 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 27* 19 *48* to *May 4* 19 *48*  
and that I last saw him alive on *May 4* 19 *48*

Immediate cause of death *Cerebral hemorrhage* DURATION *1 week*

Due to *Arteriosclerosis* *20 years*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE *W. Allen Griffith* M. D. or other  
*Berump, Ind* Date signed *5/7/48*

Address \_\_\_\_\_ Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 8 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05263 245

1. PLACE OF DEATH:  
County..... Prince Georges  
City or town..... Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 39 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Prince Geo.  
City or town..... Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 4115-32nd. Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Sophia Mowatt  
3. (b) Social Security Number

4. Sex Female  
5. Color or race White  
6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife..... Alexander Mowatt

7. Birth date of deceased (mo., day, yr.) June 20, 1875  
6. (c) If alive, give age..... years

8. AGE: Years 73 Months 11 Days If less than one day  
hrs. min.

9. Birthplace..... Washington, D.C.  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... Rudolph Saur  
13. Birthplace..... Germany

14. Maiden name..... Unknown  
15. Birthplace..... Unknown

16. Informant..... Miss Label Mowatt  
Address..... 4115-32nd. St. Mt. Rainier, Md.

17. Burial Date thereof..... May 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Fort Lincoln Cemetery  
Location..... Colmar Manor, Prince Geo. Co. Md.

18. Funeral director..... Wm. J. Valley  
Address..... 3200-R.F. Ave. Mt. Rainier, Md.

19. May 21 1948 James Seery  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 19 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27 47 to May 19 48  
and that I last saw her alive on May 18 48

Immediate cause of death..... CONGESTIVE HEART FAILURE  
DURATION ?

Due to..... Chronic MYOCARDITIS ?  
Generalized Atherosclerosis ?  
Due to..... Hypertension ?

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
Manner of injury..... Injured at work?

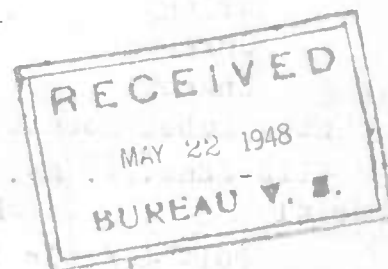
23. SIGNATURE..... David J. Clayman, MD  
M. D. or other  
Address..... 4115-30th St. Mt. Rainier Date signed..... 5/19/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:  
County Prince George's  
City or town Muirkirk  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Transient  
Hospital, institution, or street address where death occurred:  
Route # 1  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State New York County Kings  
City or town Brooklyn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 20 Plaza  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Louis Nadel

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, or divorced Married  
6.(b) Name of husband or wife Clara Nadel 6.(c) If alive, give age 65 years  
7. Birth date of deceased (mo., day, yr.) July 12. 1866  
8. AGE: Years 81 Months Days If less than one day  
hrs. min.

9. Birthplace Austria  
(Town, county, and state)  
10. Usual occupation fur business  
11. Industry or business Retired  
12. Name Unknown  
13. Birthplace Austria  
14. Maiden name Unknown  
15. Birthplace Austria

16. Informant Benjamin Nadel  
Address 205 W 34th St., N. Y. C., N. Y.  
17. transportation Date thereof May 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory New York city  
Location New York  
18. Funeral director F. Gaschi's sons  
Address Hyattsville Md.  
19. May 6, 1948 Amanda Wozney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

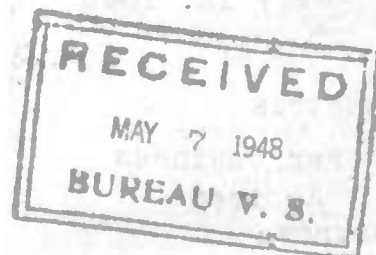
20. DATE OF DEATH May 5 48 at 10:00P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
and that I last saw him alive on  
Immediate cause of death Hemorrhage and shock  
Due to fractured skull, multiple and compound  
fracture of both legs  
Crushed pelvis and chest  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of 5/5/48  
Where did injury occur? Muirkirk P. G. Md  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Route # 1  
Means of injury ran in front of a car Injured at work? No  
Deputy Medical Examiner  
23. SIGNATURE James S. [Signature] M.D. or other  
Forestville, Md. Date signed 5/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05265 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Hyattsville Ind  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:.

(For newborn infants give residence of mother)  
 State Maryland County Prince George

City or town Hyattsville Ind

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4102 Kennedy St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Hattie Anna Norris

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 8, 1885

6. (c) If alive, give age years

8. AGE: Years 92 Months 92 Days 92 If less than one day9. Birthplace Rochester N. Y.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Frederick B. McNally13. Birthplace Canada14. Maiden name Kathleen Griffin15. Birthplace Canada16. Informant Harriet B. GriffinAddress 4102 Kennedy St. Hyattsville Ind.17. Date thereof May 10, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory Miami BeachLocation Florida18. Funeral director L. Gusche sonsAddress Hyattsville Ind19. May 10 48 Mrs. Jas. Devere

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 48 2:29 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/16 1946 to 6/19 1948and that I last saw her alive on 5/9 1948

Immediate cause of death

Gas. and failurerespiration 3 daysDue to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

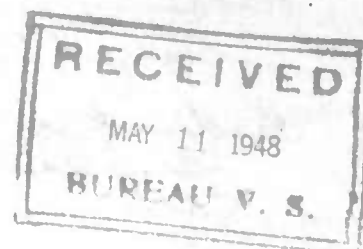
Means of injury

Injured at work?

23. SIGNATURE George H. Baggett

M. D. or other

Address 3717-38th AveDate signed 5-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05278

Reg. Dist. No. 299

## 1. PLACE OF DEATH:

County LaurelCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Davis Nursing Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1824 No Pulaski St

(If rural, give LOCATION)

2.(a) If veteran, name war 

## 3. (a) FULL NAME

Bonnie Ruthowitz

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1-12-486. (c) If alive, give age  years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

4

9. Birthplace

Baltimore Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. May 11

(Date rec'd by Registrar)

A. H. Hedden  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5 10 1948 at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 9 1948 to 5 10 1948  
and that I last saw her alive on 5 10 1948

Immediate cause of death

Polar pneumonia

DURATION

2 d.

Due to

Permaternity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

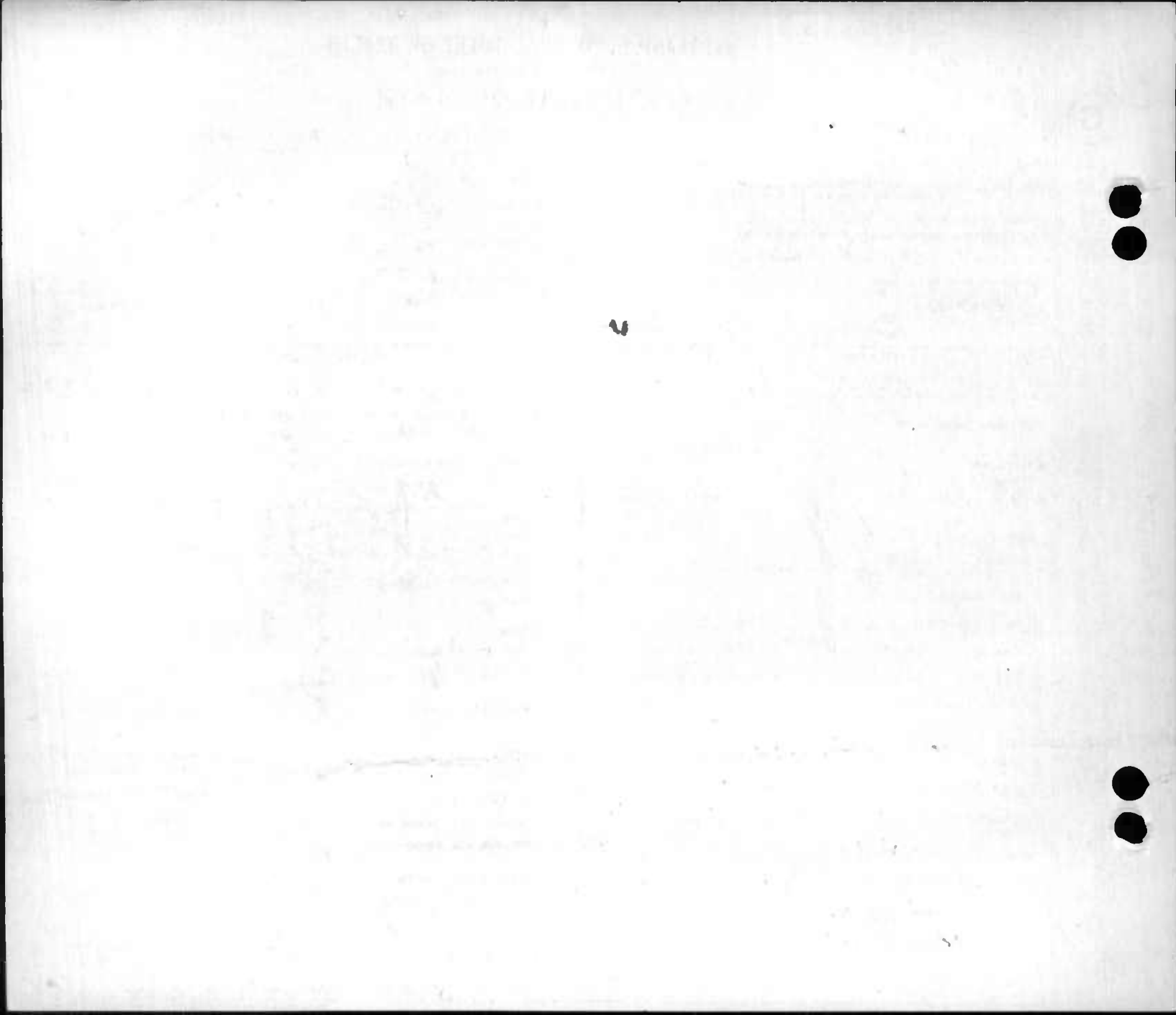
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James A. Krum  
Address Laurel Md Date signed 5/10/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince George's  
 City or town Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
Prince Georges General Hospital  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Villa Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5601 - Guinea St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3. (a) FULL NAME

Archie Gustave Owens

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lola Owens

7. Birth date of deceased (mo., day, yr.) February 6, 1874 6.(c) If alive, give age 57 years

8. AGE: Years 74 Months 7 Days 1 (If less than one day) hrs. 1 min. 0

9. Birthplace Fairfield, N. C. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name David Owens

13. Birthplace N. C.

14. Maiden name Williamson

15. Birthplace N. C.

16. Informant Mrs. Lola Owens

Address 5601 - Guinea St., Villa Heights

17. Buried Date thereof 5-16-48 (month) (day) (year)

Cemetery or crematory For Lincoln City

Location Wash. D.C.

18. Funeral director W.W. Chambers Co.

Address Riverdale, Md.

19. 5/15 19 48 Amanda Kroun Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 48 at 8:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Coronary occlusion  
Cardiovascular  
renal disease  
 Due to Cardiovascular  
renal disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. J. I. L. L.

Address Int. Health Date signed 5-13-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 18 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

932 05267 mgs  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince George's Co.City or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mabel Cannell

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George Cannell

7. Birth date of deceased (mo., day, yr.)

August 24, 1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

53

hrs. min.

9. Birthplace

Lynchburg, Va.

(Town, county, state)

10. Usual occupation

Domestic

11. Industry or business

James Campbell

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mrs. Gladys Elliott

Address

5111 Ayers Pl. S.E.

17. Removal

(Burial, cremation, or removal Which?)

Date thereof

May 7, 1948

(month) (day) (year)

Cemetery or crematory

Location

1432 1/2 Mt St next St

18. Funeral director

Address

1432 You St N.W.

May 7 1948

(Date rec'd by registrar)

19

48

James Lewis

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

5-7-48

19

at

6P

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-10

19

to

5-7-48

19

and that I last saw him alive on

5-7-48

Immediate cause of death

Congestive heart failure

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John C. Shively, Jr.

M. D. or other

Address

126 1-11 Ave

Date signed

5-7-48

RECEIVED

MAY 10 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **243**

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 6 mos., 2 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 6 mos., 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 928 P. Street, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ☒

### 3. (a) FULL NAME

MOSLEY PHILLIP

### 3. (b) Social Security Number

579-36-8738

4. Sex..... Male  
5. Color or race..... Negro  
6.(a) Single, married, widowed, or divorced..... Single

6.(b) Name of husband or wife..... ---

7. Birth date of deceased (mo., day, yr.)..... November 18, 1929  
6.(c) If alive, give age..... years

8. AGE: Years..... 18 Months..... 18 Days..... 5 If less than one day..... hrs. .... min.  
26 hrs. .... min.

9. Birthplace..... Red Oak, Virginia  
(Town, county, and state)

10. Usual occupation..... Apprentice Painter

11. Industry or business..... -

12. Name..... Elijah Mosley

13. Birthplace..... Red Oak, Virginia

14. Maiden name..... Nannie Lou Brooks

15. Birthplace..... Red Oak, Virginia

16. Informant..... Deceased

Address.....

17. Burial Date thereof..... May 17 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Glenn, Virginia

18. Funeral director..... J. E. Murray

Address..... 1337-10 N. W.

19. 5/14 19 48 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 14 1948 at 3:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/11 19 47, to 5/14 19 48

and that I last saw him alive on 5/14 19 48

Immediate cause of death..... pulmonary tuberculosis DURATION 10 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Fineman MD. M. D. or other

Address..... Glenn Dale, Md. Date signed..... 5/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Oxon Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
6415- Oxon Hill Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Oxon Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6415- Oxon Hill Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Jesse Edward Pickeral

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Lilly May Pickeral  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Feb 29, 1880  
 8. AGE: Years 68 Months ..... Days ..... If less than one day ..... hrs. .... min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation laborer  
 11. Industry or business  
 12. Name Stanley Pickeral  
 13. Birthplace Maryland  
 14. Maiden name Mary Ann Pickeral  
 15. Birthplace Maryland

16. Informant Mary H. Stubblefield  
 Address 6871 Oxon Hill Rd Oxon Hill  
 17. Burial Date thereof May 26, 1948  
 (Burial, cremation, or removal, which?) (month, day, year)  
 Cemetery or crematorium Chase Accokeek Md  
 Location Acokuk Md  
 18. Funeral director W W Chambers Jr  
 Address 577-11 St SE

19. May 24 19 48 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 48 at 6:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 19 48 to May 24 19 48  
 and that I last saw him on May 17 19 48

Immediate cause of death Coronary heart  
failure  
 Due to Cardiovascular  
disease  
 Due to

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jesse E. Pickeral M. D. or otherAddress Jesse E. Pickeral Date signed 5-24-48

RECEIVED

MAY 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 342

## 1. PLACE OF DEATH

County Prince GeorgeCity or town Seat Pleasant  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6702 - F St.

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ann M. Pickett

7. Birth date of

deceased (mo., day, yr.)

Oct. 14, 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71

hrs.

min.

9. Birthplace

Virginia  
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

FATHER

12. Name

Dallas Pickett

13. Birthplace

Seaside, N.C.

MOTHER

14. Maiden name

Seaside, N.C.

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

May 14 1948

1948

Carrie F. Campbell  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 14 1948 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 30 1948 to May 14 1948and that I last saw him alive on May 14 1948

Immediate cause of death

cerebral hemorrhage

DURATION

15 days

Due to

Hypertension with  
hypertensive heart disease10 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Brainer

M. D. question

Address

Capitol Bldg, Md.

Date signed

5/14/48

RECEIVED

MAY 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05271

245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Riverdale Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 1/2 hours  
 Hospital, institution, or street address where death occurred:  
Eugene Deland Memorial Hospital  
 How long in hospital or institution? 4 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Brentwood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4004-38th St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. Norman Plant

## 3. (b) Social Security Number

7

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Dorothy H. Plant

## 7. Birth date of deceased (mo., day, yr.)

Aug. 1. 19126. (c) If alive, give age 36 years

## 8. AGE:

Years

Months

Days

If less than one day

35

hrs.

min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

Inside repairman for

## 11. Industry or business

C. & P. Phone Co. Hyattsville Md.

## 12. Name

George Plant

## 13. Birthplace

Washington D.C.

## 14. Maiden name

Cornie Mullen

## 15. Birthplace

Martinsburg West Va.

## 16. Informant

Dorothy H. Plant wifeAddress 4004-38th St. Brentwood Md.

## 17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 10, 1948  
(Month) (day) (year)Cemetery or ~~assembly~~St. Lincoln

## Location

Washington D.C.

## 18. Funeral director

F. Pasche's son

## Address

Hyattsville Md.

## 19.

May 10 1948 Mrs. Jas. Severe  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 61948 at 11 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

## Immediate cause of death

Toxemia

## Due to

Septic meningitis

## Due to

Septic pneumonia

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of Injury

Injured at work?

## 23. SIGNATURE

Deputy Medical Examiner  
Address Hyattsville Md. Date signed 5-7-48

RECEIVED

MAY 11 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Clinton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 39 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 3. (a) FULL NAME

Joseph Proctor4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Mary Ida Proctor  
(Deceased)7. Birth date of deceased (mo., day, yr.) Jan 22 18708. AGE: Years 78 Months — Days — If less than one day — hrs. — min. —9. Birthplace Blue Plains DC  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Own Farm12. Name Washington Proctor13. Birthplace unknown14. Maiden name Elizabeth Jones15. Birthplace unknown16. Informant Fred Proctor (son)Address Clinton Md17. (Burial, cremation, or removal. Which?) Burial Date thereof May 31 - 48  
(month) (day) (year)Cemetery or crematory St. JohnsLocation Clinton Md18. Funeral director Ernest Jarvis CoAddress 1432 N. St. N. N.19. 5-28 19 48 Mrs. Alta Davis  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo.City or town Clinton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Old Alexandria Road  
(If rural, give LOCATION)2. (a) If veteran, name war —

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

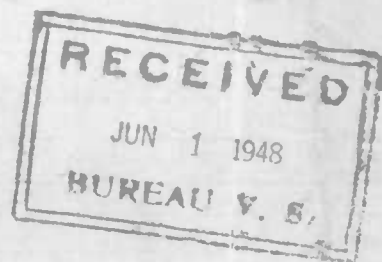
20. DATE OF DEATH May 28 1948 at 12:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1948 to May 28 1948and that I last saw him alive on May 26 1948Immediate cause of death acute coronary thrombosisDue to general arteriosclerosisDue to —Other conditions Chronic cystitis

(Include pregnancy within 8 months of death)

Major findings of operations Chronic Hypertrophy of prostateAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; —Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Breogan YattsAddress Washington 19 DCDate signed May 28 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

1700

05273

245

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred:

Island Memorial HospitalHow long in hospital or institution? 1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County SummitCity or town Summit  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3746 Floral Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war P.F.C. MARINE CORPS ✓

## 3. (a) FULL NAME

Clifford Purcell

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 20, 19288. AGE: Years 19 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cincinnati Ohio  
(Town, county, and state)10. Usual occupation P.F.C. Marine Corp.

## 11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant St. John OlsenAddress Med. Dept. U.S. Naval Hospital17. Removal Date thereof May 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location 1400 Chapin St. N.W. Wash. D.C.18. Funeral director St. John Chambers Co.Address 1400 Chapin St. N.W. Wash. D.C.19. May 25, 1948 Mrs. Jao. Severe  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1948 at 12:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Hemorrhage and shock  
Fracture of base of skull

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date 5-24-48Where did injury occur Beltzville P.F.C. Me  
(City or town) (County) (State)Injured at home, farm, industry, public place, wherever Princess Margaret HospitalCause of injury Refractory medical condition

23. SIGNATURE

Dr. Jao. Severe M.D. or other 5-25-48  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

MAY 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

9300

05274

Reg. Dist. No. 142

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Capitol Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 37 years  
 Hospital, institution, or street address where death occurred:  
404-64th Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Capitol Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 404-64th Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Agnes Rabbitt

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Charles Frederick Rabbitt 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 16, 1872  
 8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1945 to May 24 1948  
 and that I last saw him alive on May 24 1948.

Immediate cause of death Coronary Arteriosclerosis DURATION 1 day  
 Due to Anterior Chroatic Heart Disease 5 years  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE William Brannin M. D. or other \_\_\_\_\_Address Capitol Heights, Md. Date signed 5/25/48

9. Birthplace Kerry County, Ireland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name Maurice ~~Cornell~~ Gairley  
 13. Birthplace Ireland  
 14. Maiden name Delush Cornell  
 15. Birthplace Ireland  
 16. Informant Mrs. Agnes de Grace  
 Address 404-64th Ave, Capitol Heights, Md.  
 17. Burial Date thereof May 28/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Mt Olivet Cemetery  
 Location Washington D.C.  
 18. Funeral director Spand's  
 Address 3821-14th St. N.W. Wash. D.C.  
 19. May 25 1948 Carrie J. Campbell Registrar  
 (Date rec'd by registrar)

RECEIVED

MAY 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

### 1. PLACE OF DEATH:

County Prince Georges  
City or town 6292 Allentown Rd  
Washington  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 mo  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr Georges  
City or town Allentown Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6292 Allentown Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Phillips Clarke Readmond

### 3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife James W Headmond

7. Birth date of deceased (mo., day, yr.) Sept 20 1883 6. (c) If alive, give age 72 years

8. AGE: Years 64 Months Days If less than one day

9. Birthplace St Marys County  
(Town, county, and state)

10. Usual occupation Produce Seller

11. Industry or business Own Business

FATHER 12. Name Jefferson Readmond

13. Birthplace St Marys County Md

MOTHER 14. Maiden name Clarke

15. Birthplace St Marys Co, Md

16. Informant Gregory Readmond

Address 6328 Allentown Rd DC 20

17. Burial Buried Date thereof May 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Johns Cemetery

Location Hollybrook Rd St Marys Co

18. Funeral director Arthur E. Simmons

Address 2007 Nichols St S.E.

19. May 10 1948 Arthur E. Simmons  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1948 at 6:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to May 10 1948 and that I last saw him alive on May 10 1948

Immediate cause of death Carcinoma of stomach with metastases

Due to metastases  
Due to General Arteriosclerosis  
Other conditions Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations none  
Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no

Accident, suicide, or homicide no Date of

Where did injury occur? no  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Paul C. Van Dyke M. D.

Address Washington 1900 Date signed May 10 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

### 1. PLACE OF DEATH:

County Prince George  
City or town Maryland Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
6411-13 Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Maryland Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6411-13 Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

James Frank Rose

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Helen C. Rose

7. Birth date of deceased (mo., day, yr.) June 12, 1878 6. (c) If alive, give age 67 years

8. AGE: 70 Years 4 Months 13 Days If less than one day hrs. min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Electrical

12. Name Howard M. Rose

13. Birthplace Virginia

14. Maiden name Mattha Griffith

15. Birthplace Virginia

16. Informant Partha Jones

Address 6411-1350 Mid Park, Wash.

17. (Burial, cremation, or removal, if any) Date thereof May 28, 1948  
(month) (day) (year)

Cemetery or crematory Addison Chapel

Location Seat Pleasant Md.

18. Funeral director J. William Lewis

Address 300-4th St N.E. Wash D.C.

19. May 28 19 48 Carrie F. Campbell  
(Date rec'd by Registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH May 25, 1948 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Coronary occlusion  
Due to Cardiovascular renal disease  
Due to

Other conditions Prostatectomy April 29, 1948  
Condition for which operation was performed  
(Include pregnancy within 3 months of death) unknown

Major findings of operations 4/29/48  
Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick H. H. H.  
M.D. or other

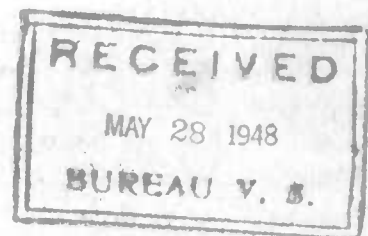
Address Frederick H. H. H. Date signed 5-26-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 6867

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

23. SIGNATURE

M. D. or other

Address

Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

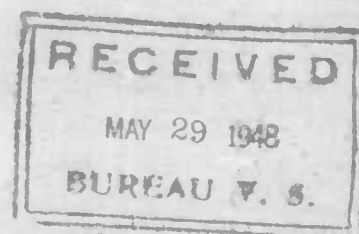
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



RECEIVED

MAY 29 1948

BUREAU V. S.

Evidence for change of  
birth date shown on:

FILE No. G 116 JUN 17 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1310 05279231

1. PLACE OF DEATH:

County Prince Georges  
City or town Prince Georges  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years  
Hospital, institution, or street address where death occurred:  
R. F. Anderson, Md.

How long in hospital or institution?

3. (a) FULL NAME

Otto Heidel  
Sex Male Color White b. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Agnes Heidel

7. Birth date of deceased (mo., day, yr.) December 14, 1876 1876

8. AGE: 72 Years 4 Months 26 Days If less than one day 4 hrs. min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired 12 years

12. Name Joseph Heidel

13. Birthplace Austria

14. Maiden name Agnes Woffa

15. Birthplace Austria

16. Informant Otto Heidel

17. Burial Date thereof May 14, 1948

(Burial, cremation, or removal. Which?) Burial

Cemetery or crematory St. Lincoln

Location Washington D.C.

18. Funeral director F. H. Harrison

Address Hyattsville Md.

19. 5/10/48 Amanda Lawrence

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Prince Georges, Md.  
(If outside city or town limits, write RURAL and give nearest town)

2. (a) If veteran, name was R. F. Anderson, Md.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1948 at 4:40 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased on May 11, 1948

and that I last saw him alive on May 5, 1948

Immediate cause of death Cardiac Decease

Due to Vascular Disease

Due to Failure

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

24. SIGNATURE

Address

25. SIGNATURE

Address

26. SIGNATURE

Address

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*[Faint handwritten notes, possibly "L. H. ..."]*

*[Faint handwritten notes, possibly "L. H. ..."]*

*[Faint handwritten notes, possibly "L. H. ..."]*

*[Faint handwritten notes, possibly "L. H. ..."]*

*[Faint handwritten notes, possibly "L. H. ..."]*

*[Faint handwritten notes, possibly "L. H. ..."]*

RECEIVED  
MAY 21 1948  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05280

Reg. Dist. No. 245

### 1. PLACE OF DEATH

County Prs Georges Co  
City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prs Georges  
City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4606 Hamilton St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Reuben Keller small

### 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lula May small  
7. Birth date of deceased (mo., day, yr.) March 7, 1880  
6.(c) If alive, give age 60 years

8. AGE: Years 68 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Penna  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business store keeper

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Lula May small

Address Hyattsville Md.

17. Burial Date thereof May 28 1949  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Nat. Cem.

Location Va.

18. Funeral director J. H. Arch's Sons

Address Hyattsville Md.

19. May 28 1949 J. H. Arch's Sons Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1948 at 4:28 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to 1948 and that I last saw him alive on 5-25-48

Immediate cause of death Cerebral haem. DURATION 3 hrs

Due to Hypertension 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Arch

Address Hyattsville Md Date signed 5/26/48

MARGIN RESERVED FOR FINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 29 1948

**BUREAU V. S.**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

596 05281 239  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Prince George

City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 10th St  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Edith Pearl Smith

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Albert Smith

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30, 1890

8. AGE: Years 58 Months 3 Days 11 It less than one day hrs. min.

9. Birthplace Harford Co. Maryland  
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business None

12. Name William Riley Bradford

13. Birthplace Maryland

14. Maiden name Mrs Mary Thompson

15. Birthplace Harford County, Md

16. Informant Albert Smith

Address 204 10th St, Laurel Md

17. Burial Date thereof May 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Long Hill Cemetery

Location Laurel Maryland

18. Funeral director W. W. Davidson

Address Laurel Maryland

19. May 14 19 48 M Brashear  
(Date read by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 48 at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 46 to May 11 19 48  
and that I last saw him alive on May 10 19 48

Immediate cause of death aplastic anemia DURATION 8 mo

Due to undetermined

Due to

Other conditions pernicious anemia hypertrophic arthritis 10 yrs. 10 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. Davidson M.D. M. D. or other

Address Laurel, Md. Date signed 5/11/48

MARGIN RESERVED FOR BINDING

1

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

### 1. PLACE OF DEATH:

County Prince Geo.  
City or town CAPITOL HIGHTS  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 31 YRS  
Hospital, institution, or street address where death occurred:  
—  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County P. G. C.  
City or town CAPITOL HIGHTS  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 806-61st Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war —

### 3. (a) FULL NAME

JOSEPH M. STANS BURY

### 3. (b) Social Security Number

NONE

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced MARRIED  
6.(b) Name of husband or wife ALICE GRACE  
6.(c) If alive, give age 58 years  
7. Birth date of deceased (mo., day, yr.) JULY 13<sup>th</sup> 1883  
8. AGE: Years 64 Months — Days — If less than one day — hrs. — min.

9. Birthplace MD.  
(Town, county, and state)  
10. Usual occupation STOCK ASSEMBLER  
11. Industry or business RETIRED BUREAU ENGRAVING  
12. Name BENJAMIN STANSBURY  
13. Birthplace MD  
14. Maiden name HENREITER CHUBB  
15. Birthplace MD

16. Informant ALICE STANSBURY  
Address 806-61st CAPITOL HIGHTS  
Prinial  
17. (Burial, cremation, or removal) Which? Burial Date thereof 5-19-1948  
(month) (day) (year)  
Cemetery or crematory Cedar Hill  
Switzland, Ind.  
Location W.H. Chambers Co  
18. Funeral director J.T. E. Wash. D.C.  
Address 517-11th St

19. May 16 19 48 Carrie F. Campbell  
(Date recd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 16 19 48 at 4:30 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 19 47 to MAY 15 19 48  
and that I last saw him alive on MAY 15 19 48

Immediate cause of death CARCINOMA  
CARCINOMA  
Due to CARCINOMA LIVER  
Due to —  
Other conditions —

(Include pregnancy within 3 months of death)  
Major findings of operations — Date of op. —  
Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide — Date of —  
Where did injury occur? — (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) —  
Means of injury — Injured at work? —

23. SIGNATURE Chas V. Pate MD  
M. D. or other —  
Address 335 W 1st N.E Date signed 5/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 20 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 mos., 27 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 8 mos., 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1216 I. St., N. W., Apt. #7  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harry Stathis

## 3. (b) Social Security Number

579-03-2315

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

February 10, 1895

8. AGE:

53

Years

53

Months

2

Days

23

If less than one day

hrs.

min.

8. Birthplace

Greece

(Town, county, and state)

10. Usual occupation

Waiter

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name

Peter Stathis

13. Birthplace

Greece

14. Maiden name

? Zahoro

15. Birthplace

Greece

16. Informant

Deceased

Address

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

5 5 48  
(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

Prince Georges County, Maryland

18. Funeral director

W. W. Chambers Co.

Address

1400 Chapin St NW

19.

5/4  
(Date rec'd by registrar)

19.

48 Rowland S. Phillips  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 319 48, at 10:50 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5 19 47, to May 3 19 48and that I last saw him alive on May 3 19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

8 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finucane MD  
M. D. or other

Address

Glenn Dale, Md.

Date signed

5/3/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1248-05288-231

### 1. PLACE OF DEATH:

County PRINCE GEORGE'S  
City or town CHEVERLY  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

PRINCE GEORGE'S HOSPITAL

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Washington  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 913 Quincy St. N.E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

EVA MAY SWEENEY

### 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife NORMAN C SWEENEY

7. Birth date of deceased (mo., day, yr.)

SEPT 24 1881

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66

hrs. min.

9. Birthplace

ALEXANDRIA, VIRGINIA  
(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

MOTHER FATHER

12. Name

WILLIAM J GEORGE

13. Birthplace

VA.

14. Maiden name

SARAH LLOYD

15. Birthplace

VA.

16. Informant

NORMAN C SWEENEY

Address

913 QUINCY ST NE

17.

BURIAL

Date thereof

MAY 28 1948  
(month) (day) (year)

Cemetery or crematory

FT. LINCOLN CEMETARY

Location

WASHINGTON D.C.

18. Funeral director

W W CHAMBERS CO

Address

517 11 ST SE D.C.

19.

5/25 1948

Amanda Doney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1948 to May 25 1948 and that I last saw him alive on May 25 1948

Immediate cause of death

myocardial infarction

DURATION

Due to

Coronary artery disease

Due to

Other conditions

none

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel W. Fraumeni MD

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 27 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

### 1. PLACE OF DEATH:

County Prince George's  
City or town Green Hill Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George's  
City or town Green Hill Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6250 - St Barnabas Rd SE  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Eleanor Tanner

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Caucasian 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1874 6.(c) If alive, give age years

8. AGE: Years 74 Months Days If less than one day hrs. min.

9. Birthplace Green Hill Md  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Augustus Borok

13. Birthplace Pa

14. Maiden name Cynthia Kolbert

15. Birthplace Charles Co, Md

16. Informant Dwila T. T. T.

Address 6240 St Barnabas Rd

17. Burial (Burial, cremation, or removal, Which?) 20. PC 35 Date thereof (month) (day) (year) May 24 1948

Cemetery or crematorium St Paul's Methodist

Location Green Hill

18. Funeral director Robert J. Mason

Address 2500 - Nichols Ave SE

19. May 26 1948 Edua Collins Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1948 to May 25 1948 and that I last saw her alive on May 24 1948

Immediate cause of death Emaciation and starvation DURATION 5 weeks

Due to Carcinoma of the stomach

Due to

Other conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lusher J. Scott M.D.

M. D. or other

Address 2504 Nichols Ave SE Date signed 5-25-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1874

74

1948

RECEIVED  
JUN 7 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 18 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2401 Shannon Place, S. E.,  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

MELL TIBBS

## 3. (b) Social Security Number

---

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife..... Wilson R. Tibbs

7. Birth date of deceased (mo., day, yr.) October 21, 1876 6.(c) If alive, give age..... years

8. AGE: Years Months Days It less than one day  
 71 71 6 24 hrs. min.

9. Birthplace..... Parole, Maryland  
 (Town, county, and state)

10. Usual occupation..... Seamstress

11. Industry or business.....

FATHER 12. Name..... Thomas H. Brooks  
 13. Birthplace..... Chesterfield, Maryland

MOTHER 14. Maiden name..... Mary F. Hall  
 15. Birthplace..... Chesterfield, Maryland

16. Informant..... Deceased

Address.....

17. Removal Date thereof..... 5/17/48.  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....  
 Location..... to Washington DC.

18. Funeral director..... H.S. Walker Trust & Sons  
 Address..... 467 N. St. N. W.  
 5/17 48 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 16<sup>th</sup> 1948, at 6<sup>30</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1948 to May 15 1948  
 and that I last saw her alive on May 15<sup>th</sup> 1948

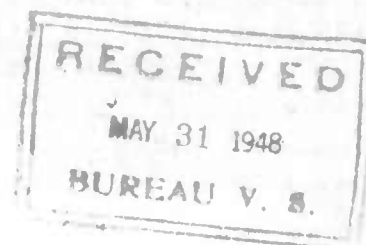
Immediate cause of death..... PULMONARY TUBERCULOSIS 13 yrs  
 DURATION

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)  
 Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Pincus MD  
 M. D. or other  
 Address..... Glen Dale, Md., Date signed..... 5/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05287 243

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town District Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
998 County Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town District Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 998- County Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice Virginia Tilghman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Caucasian 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife William Tilghman  
 6.(c) If alive, give age 69 years  
 7. Birth date of deceased (mo., day, yr.) February 15, 1877  
 8. AGE: Years 71 Months 0 Days 0 If less than one day  
 hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Gen. Home  
 FATHER 12. Name Charles Hawthorn  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Mamie Stevenson  
 15. Birthplace Maryland

16. Informant William Tilghman  
 Address 998 County Road, Dist. Heights  
 17. Burial Date thereof May 28, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Mt. Calvary Catholic  
 Location Forestville, Md.  
 18. Funeral director Henry S. Washington & Sons  
 Address 467 N. St. N.W.  
 19. May 25 19 48 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1948 at 12:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 to 19  
 and that I last saw him alive on 19

Immediate cause of death Sudden cerebral hemorrhage DURATION

Due to Cardiovascular renal disease  
 Due to

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury injured at work?

23. SIGNATURE James D. Boyd M. D. or other  
 Address Forestville, Md. Date signed 5-25-48

**RECEIVED**

MAY 28 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *930 05288 n/5*

## 1. PLACE OF DEATH:

County *P. George*  
 City or town *Mt. Rainier*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *5 months*  
 Hospital, institution, or street address where death occurred: *—*  
 How long in hospital or institution? *—*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince George's*  
 City or town *Mount Rainier*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *4303 30th Street*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war *NONE*

## 3. (a) FULL NAME

*WILLIAM PATRICK TOBIN*

## 3. (b) Social Security Number

*NONE*

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*MALE**WHITE**MARRIED*6. (b) Name of husband or wife *Alma Hunt Tobin*7. Birth date of deceased (mo., day, yr.) *February 14, 1866*

8. (c) If alive, give age years

8. AGE: Years *82* Months *3* Days *10* If less than one day hrs. min.9. Birthplace *Washington D.C.*

(Town, County, and state)

10. Usual occupation *Stone cutter & Bricklayer Ret.*

## 11. Industry or business

12. Name *William Patrick Tobin Sr.*13. Birthplace *Ireland*14. Maiden name *Ellen O'Reilly*15. Birthplace *Ireland*16. Informant *Mrs. Julia T. Reed*Address *4303 30th St. Mt. Rainier Md.*17. *Burial* Date thereof *May 28, 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mount Olivet Cemetery*Location *Washington D.C.*18. Funeral director *W. W. CHAMBERS CO*Address *5801 Cleveland Ave., Riverdale, Md.*19. *May 25, 1948* *Mrs. Jas. Severe*

(Date rec'd by registrar) (Signature of registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 24, 1948* at *9:50 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 2, 1948* to *May 24, 1948* and that I last saw him alive on *May 24, 1948*

Immediate cause of death

*Arteriosclerotic Heart Disease*

DURATION

*Unknown*

Due to

*Generalized Arteriosclerosis*

Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Irwin H. Grossgreen* M. D. or other *MD* Address *Mt. Rainier, Md* Date signed *5-24-48*



CERTIFICATE OF DEATH

STATE OF NEW YORK

STATE OF NEW YORK

DEATH RECORD

RECEIVED  
MAY 27 1948  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges County  
City or town Cheverly, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Prince Georges General Hospital  
How long in hospital or institution? 7 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
City or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Charles Tomlinson

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

W

Married

6. (b) Name of husband or wife Mary Anna Tomlinson

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1873

8. AGE: Years Months Days If less than one day  
75 4 15 hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name John Tomlinson

13. Birthplace England

14. Maiden name Elizabeth Braxwell

15. Birthplace Maryland

16. Informant Mrs. Beatrice Seese - Daughter

Address 1616 Potomac Ave. S.E. Wash. D.C.

17. Burial Date thereof May 29, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory W.H. Carmel

Location Upper Marlboro, P. G. Co., Md.

18. Funeral director Ritchie Bros.

Address Upper Marlboro, Md.

19. 5/27 19 48 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 48 at 12:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 19 48 to May 26 19 48  
and that I last saw him alive on May 25 19 48

Immediate cause of death  
Hypertensive Crisis  
Myocardial Rupture  
Refractory Renal Disease  
Nephrosclerosis  
Due to 5 years  
Bronchial Pneumonia  
Due to 6 years  
Arteriosclerosis  
Other conditions 10 yrs

#### DURATION

(Include pregnancy within 3 months of death)

Major findings of operations None  
Date of op. \_\_\_\_\_

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James E. Tancer M.D.  
Upper Marlboro, Md. M. D. or other  
Date signed 5-26-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 31 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 052994

### 1. PLACE OF DEATH:

County Prince George  
City or town Rural - Clinton, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs  
Hospital, institution or street address where death occurred:  
- Route 2  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prince Georges  
City or town (Rural) Clinton, Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 2  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Tura Lee

Valentine

### 3. (b) Social Security Number

#### 4. Sex

Female

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

#### 6. (b) Name of husband or wife

William A. Valentine

#### 6. (c) If alive, give age

49 years

#### 7. Birth date of deceased (mo., day, yr.)

Oct 22, 1916

#### 8. AGE:

Years

Months

Days

If less than one day

31

hrs.

min.

#### 9. Birthplace

Ala

(Town, county, and state)

#### 10. Usual occupation

None

#### 11. Industry or business

FATHER  
MOTHER

#### 12. Name

Barnes Snow

#### 13. Birthplace

Ala

#### 14. Maiden name

Mary Brooks

#### 15. Birthplace

Opp, Alabama

#### 16. Informant

William A. Valentine

#### Address

Clinton, Md.

#### 17.

Burial  
(Burial, cremation, or removal, Which?)

#### Date thereof

5/28/48  
(month) (day) (year)

#### Cemetery or crematory

Fort Lincoln

#### Location

Md

#### 18. Funeral director

W. Warren Taltavull

#### Address

3619-14<sup>th</sup> St. N.W. Wash. D.C.

#### 19.

May 25 1948  
(Date rec'd by registrar)

Remond  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1946 to May 25 1948

and that I last saw her alive on May 23 1948

#### Immediate cause of death

Carcinoma of kidneys with metastasis

#### DURATION

2 yrs.

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

#### Means of injury

Injured at work?

#### 23. SIGNATURE

Thomas F Collins

M. D. or other

Address 322-H NE Date signed 5-25-48

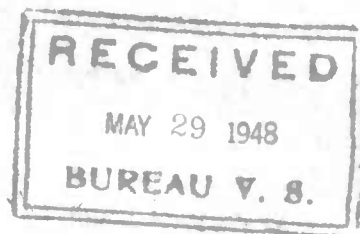
MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948-5-25  
31-  
1916



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05291-245

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Riverdale Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4700 Bittenhouse St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Theodore William Venemann

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Lillian M Venemann6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) Feb 21, 1883.

## 8. AGE:

Years

Months

Days

If less than one day

65

hrs. min.

9. Birthplace Evansville Indiana.  
(Town, county, and state)10. Usual occupation retired

## 11. Industry or business

12. Name Robert Theodore Venemann13. Birthplace Indiana14. Maiden name Jennie A. Gerald15. Birthplace Indiana16. Informant Mrs Lillian M. VenemannAddress Riverdale Maryland17. Burial Date thereof May 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory George WashingtonLocation Hyattsville Maryland18. Funeral director F. Gasch's SonsAddress Hyattsville Maryland19. May 13 H. J. Janz Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1948 19 48 at 11.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1943 to May 1948  
and that I last saw him alive on May 10, 1948

Immediate cause of death

Carcinoma of prostate

DURATION

6 mo

Due to

Due to

Other conditions General arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Janz M. D. or otherAddress Riverdale Md Date signed 5-12-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges

City or town "Camp Springs" and  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

## 3. (a) FULL NAME

Cavalyn Rose Walter

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

John Bernard Walter

7. Birth date of deceased (mo., day, yr.)

Sept 25 1876

6. (c) If alive, give age 75 years

8. AGE:

Years 71

Months -

Days -

If less than one day

hrs. -

min. -

9. Birthplace

Charles Co. Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

MOTHER FATHER

12. Name

Thomas Marr

13. Birthplace

Charles County Md.

14. Maiden name

Floise Caroline Marr

15. Birthplace

Charles County Md.

16. Informant

John Bernard Walter Jr.

Address

1317 K St. S.E. Washington DC

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

5/22/48

Cemetery or crematory

St. John's

Location

Clinton, Md.

18. Funeral director

Hunt &amp; Ryan

Address

Washington, Md.

19. (Date rec'd by registrar)

5/20/48

19

48

M. D. O'Connor

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo

City or town 17200 Brinkley Road SE  
(If outside city or town limits, write RURAL and give nearest town)Street No. Washington 20 WC  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1948 at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 1948 to May 20 1948

and that I last saw him alive on May 19 1948

Immediate cause of death

Cerebral artery sclerosis with subarachnoid hemorrhage and

paralysis left side of body

Due to

Due to

Other conditions

Chronic Cholelithiasis  
(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide natural causes

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Washington 1900

Date signed 4/20/48

RECEIVED  
MAY 8 1948  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Comedy Hills  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 hrs.  
Hospital, institution, or street address where death occurred:  
517-70th Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Comedy Hills  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 517-70th Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Linda Jean Ward

### 3. (b) Social Security Number

#### 4. Sex

Female

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Single

#### 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 30, 1947

8. AGE: Years \_\_\_\_\_ Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington D.C.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name William Ward

13. Birthplace Kentucky

14. Maiden name Elsie Troy

15. Birthplace Washington D.C.

16. Informant Mrs. Elsie Ward

Address 517-70th St, Comedy Hills

17. Burial Date thereof May 14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Natl.

Location Suitland Md.

18. Funeral director W.W. Chambers Co.

Address 517-11th St. Wash. D.C.

19. May 12 19 48 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 48 at 3:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Asphyxia

Due to Ingestion in bed

clothing

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-12-48

Where did injury occur Comedy Hills (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Keepsake Medical Center

23. SIGNATURE Carrie F. Campbell M.D. or other

Address 517-70th St Date signed May 12-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

05294

Reg. Dist. No. 244

## 1. PLACE OF DEATH:

County PRINCE Geo.City or town SEAT Pleasant  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 YRSHospital, institution, or street address where death occurred:  
6220 Foote StreetHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County P.G.C.City or town SEAT Pleasant  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6220 - Foote St  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

HOWISA WARD

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White WIDOW6.(b) Name of husband William A.7. Birth date of deceased (mo., day, yr.) Nov 11 1882  
6.(c) If alive, give age — years8. AGE: Years 93 Months — Days — If less than one day — hrs. — min.9. Birthplace MD.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant JAMES M. ROBERTSAddress 6220 Foote St.17. Burial Date thereof 9/22/48  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory Adams ChapelLocation Seat Pleasant Md18. Funeral director W.W. Chambers Co.Address 517-11th St. Wash. D.C.19. May 20 1948 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1948 at 6:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940 to May 20 1948.  
and that I last saw him alive on May 19 1948.Immediate cause of death Generalized arteriosclerosis with arteriosclerotic heart disease  
DURATION 15 yearsDue to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE William Brainerd M. D. —Address Capitol Heights, Md. Date signed May 20 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

470

05295

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Cherry Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 hours  
 Hospital, institution, or street address where death occurred:  
Prince Georges Hospital  
 How long in hospital or institution? 20 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince Georges  
 City or town Lanham - Landover  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6116 Orsman Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John G. Wentz

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Sadie Wentz  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct 20, 1878  
 8. AGE: Years 69 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Charles Co. Md.  
(Town, county, and state)10. Usual occupation Restauranteur

11. Industry or business

12. Name John A. Wentz13. Birthplace Charles Co. Md.14. Maiden name Martina Mattingly15. Birthplace Md.16. Informant Sadie WentzAddress 6116 Orsman Rd - Lanham17. Burial June 2, 1948  
(Burial, cremation, or removal Which?) Date thereof (month) (day) (year)Cemetery or crematory EvergreenLocation Bladensburg Md18. Funeral director F. L. S. SonsAddress Hyattsville Md.19. May 31 19 48 Amanda Woroney  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 May 19 48 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Primarybronchogenic carcinoma

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

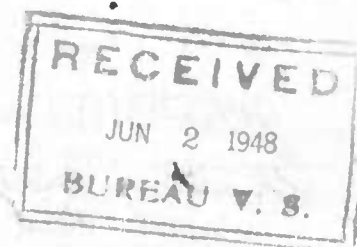
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE C. W. 12 W. P.Address H. H. 12 W. P.Date signed 5-29-48



Evidence for change of  
age and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 11 MAY 26 1948

CERTIFICATE OF DEATH

05296  
Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 3 mos., 14 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 3 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 3102 - 28th St., S. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME

JESSIE B. WHITBY

3. (b) Social Security Number

-

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife..... Joseph Henry Whitby

7. Birth date of deceased (mo., day, yr.)..... October 26, 1885

8. AGE: Years..... Months..... Days..... If less than one day  
62 5/11 5/11 62 6 17 ..... hrs. .... min.

9. Birthplace..... Edgefield, South Carolina  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Thomas Jester  
13. Birthplace..... ? South Carolina

14. Maiden name..... Sarah Hamilton  
15. Birthplace..... ? South Carolina

16. Informant..... Deceased

Address

17. Removal..... Date thereof..... 5/13/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location

18. Funeral director.....  
Address..... 1300 N. E. N. W.

19. 5/13 48 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 1948 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 28 1948 to May 13 1948  
and that I last saw her alive on May 13 1948

Immediate cause of death..... Pulmonary Tuberculosis  
DURATION 5 mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leonard M.D.  
M. D. or other  
Address..... Glenn Dale, MD Date signed 5/13/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince Georges County, MarylandCity or town College Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town College Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4507 AMHERST ROAD, COLLEGE PARK, MD.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MRS. HELEN R. WHITEHOUSE

## 3. (b) Social Security Number

4. Sex <b>Female</b>	5. Color or race <b>White</b>	6. (a) Single, married, widowed, or divorced <b>MARRIED</b>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife Mr. Whitehouse ; William E.~~XXXXXXXXXX~~7. Birth date of deceased (mo., day, yr.) June 27, 1897

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>10</u>		hrs. min.

9. Birthplace WASHINGTON, D.C.  
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name William C. Rosenbusch13. Birthplace Washington, D.C.MOTHER 14. Maiden name Lena Wehrle15. Birthplace Washington, D.C.16. Informant Lloyd A. Rosenbusch (Brother)Address Washington, D.C.17. Removal Date thereof May 17th, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location 1300 - N. Street, N.W., Wash. D.C.18. Funeral director Martin W. LyonsAddress 1300 N. Street, N.W., Wash. D.C.19. May 17 1948 James Levy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th, 1948 at 8:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23 1944 to Present 5/17 1948and that I last saw him alive on April 27 1948

Immediate cause of death	DURATION
<u>Carcinoma of right breast, extensive replacement of liver, lungs and many bones.</u>	
Due to	
Due to	

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Right Mastectomy Nov. 1942and carcinoma found Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edgar M. McPeck M. D. or otherAddress 1835 Eye St., N.W. - Wash. D.C. 5/17/48  
Date signed

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d 05298

Reg. Dist. No. 148

## 1. PLACE OF DEATH:

County... Prince Georges  
 City or town... Chapel Oaks  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 1/2 yrs.  
 Hospital, institution, or street address where death occurred:  
1413 - 57th St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)  
 State... Maryland County... Prince Georges  
 City or town... Chapel Oaks  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1413 - 57th St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mamie Wilson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Robert Lee Wilson  
 6. (c) If alive, give age 67 years  
 7. Birth date of deceased (mo., day, yr.) March 13, 1885  
 8. AGE: Years 63 Months 1 Days 23 If less than one day  
 8. (hrs. min.)  
 9. Birthplace Penn. Co. Va.  
 (Town, county, and state)  
 10. Usual occupation None

## 11. Industry or business

MOTHER FATHER  
 12. Name Isaac Thomas  
 13. Birthplace Penn. Co., Va.  
 14. Maiden name Unknown  
 15. Birthplace

16. Informant Mrs. Elnora Thomas  
 Address 1413 - 57th St. Place

17. Removal Date thereof May - 6 - 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory  
 Location Washington D.C.  
Malvina Schey Inc.

18. Funeral director  
 Address 424 - R St. N.W.

19. May 6 19 48 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 48, at 6 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 21 19 48, to May 6 19 48  
 and that I last saw her alive on May 6 19 48

Immediate cause of death Cerebral Hemorrhage DURATION

Due to Hypertensive Cardiovascular Disease

Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE John Robinson, M.D. M. D. or other  
 Address 1001 Eastern Ave. N.E. Date signed 5/6/48

RECEIVED

MAY 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05290

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 yr., 3 mos., 1 day  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 1 yr., 3 mos., 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 811 Dixon Ct., S. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

Millon Wimbush

## 3. (b) Social Security Number

577-32-3330

4. Sex..... Male  
 5. Color or race..... Negro  
 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife..... - - -

7. Birth date of deceased (mo., day, yr.)..... May 20, 1929  
 8. AGE: Years..... 18 Months..... 11 Days..... 22 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation..... Restaurant Work  
 11. Industry or business..... -

12. Name..... Clifford Wimbush  
 13. Birthplace..... Lynnhburg, Virginia  
 14. Maiden name..... Julia Thompson  
 15. Birthplace..... Brandy, Virginia

16. Informant..... Deceased  
 Address.....

17. Removal to O.C.H. or other Date thereof..... 5 17 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....  
 Location.....

19. Funeral director..... Dr. Daniel Leo Funicane  
 Address..... Glenn Dale San, Glenn Dale Md

19. 5/17 48 Rowland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 5/12 19 48 10 25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/10 19 47 to 5/12 19 48  
 and that I last saw him alive on 5/12 19 48

Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION 16 mos.

Due to.....

Due to.....

Other conditions..... Osteomyelitis of right inferior maxillary  
 (Include pregnancy within 8 months of death)

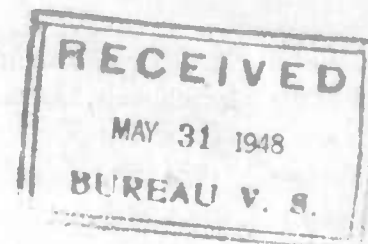
Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Funicane MD  
 M. D. or other  
 Address..... Glenn Dale Md Date signed..... 5/12/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 92 daysHospital, institution, or street address where death occurred:  
Prince Georges General HospitalHow long in hospital or institution? 92 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Mitchellville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Rosie Wood

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Frank Wood7. Birth date of deceased (mo., day, yr.) Nov. 9th, 1869

8. AGE: Years Months Days If less than one day

78 6 2 hrs. min.9. Birthplace (Town, county, and state) Md.10. Usual occupation Funeral Director11. Industry or business Funeral12. Name Leonard Daisy13. Birthplace Germany14. Maiden name Detrich Phipps15. Birthplace Md.16. Informant Mrs. Clarence ForeacreAddress Mitchellville, Md.17. Burial Date thereof May 19, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Barnabas CemeteryLocation Leeland, Md.18. Funeral director J. Kasch's SonsAddress Mitchellville, Md.19. 5/17 48 Amanda Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 48 at 6:50 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 19 48, to May 16 19 48and that I last saw him alive on May 15 19 48Immediate cause of death Carcinoma ofPancreas DURATION 8 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions arteriosclerosis 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma ofPancreas Date of op. 6-30-47Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James G. Parson M.D.Address Upper Marlboro, Md. Date signed 5-17-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County Prince George's  
City or town Mitchellville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 18 years  
Hospital, institution, or street address where death occurred:  
Route 2 Box 13  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Mitchellville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 2 Box 13  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Henrietta Prindell Wright

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Charles Wright  
6. (c) If alive, give age 51 years  
7. Birth date of deceased (mo., day, yr.) April 29, 1901  
8. AGE: Years 47 Months Days Less than one day  
hrs. min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Own Home  
12. Name Thomas Prindell  
13. Birthplace Maryland  
14. Maiden name Rachel Collins  
15. Birthplace Maryland

16. Informant Cora Wright  
Address Mitchellville, Md  
17. Buried Date thereof May 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Carroll Chapel  
Location Mitchellville, Md  
18. Funeral director Glenn Foreacre  
Address Mitchellville, Md

19. May 24 19 48 Louise H Peach  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48 at 12:00 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 to 19  
and that I last saw h. alive on 19

Immediate cause of death acute congestive heart failure  
DUE TO cardiovascular renal disease  
Due to  
Other conditions  
(Include pregnancy within 8 months of death)

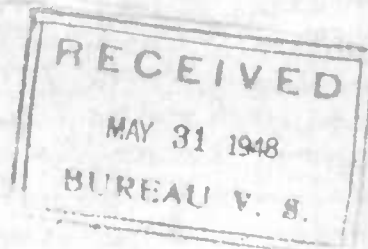
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE James D. Boyd M. D. or other  
Address Mitchellville, Md Date signed 5-23-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05302

930

Reg. Dist. No. 243

1. PLACE OF DEATH  
County Prince George's  
City or town Bowie Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 years  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Bowie Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME John William Yingling  
3.(b) Social Security Number 216-03-8778

4. Sex Male  
5. Color or race white  
6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Mrs. Agnes Yingling  
6.(c) If alive, give age 48 years  
7. Birth date of deceased (mo., day, yr.) June 22, 1882  
8. AGE: Years 65 Months Days If less than one day

9. Birthplace Westminister Maryland  
(Town, county, and state)  
10. Usual occupation Iron Molder  
11. Industry or business U. S. Navy Yard  
12. Name Marshall Yingling  
13. Birthplace Westminister Maryland  
14. Maiden name Alice Lance  
15. Birthplace Westminister Maryland  
16. Informant Mrs Agnes Yingling  
Address Bowies Maryland  
17. Burial Date thereof May 5, 1948.  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Fort Lincoln Cemetery  
Location Washington D. C.  
18. Funeral director F. Gasch's Sons  
Address Hyattsville Maryland  
19. May 4 19 48 Wm. J. W. Yingling  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH May 3, 1948 19 48 at 2:55P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30, 1947 to May 3, 1948  
and that I last saw him alive on May 3, 1948  
Immediate cause of death  
Congestive heart failure  
myocardial infarction  
Generalized arteriosclerosis  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
Signature Sam W. W. W. W. W.  
M. D. or other  
Address 30-B Bridge St. Greenbelt, Md. Date signed 5/4/48

